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NOVEMBER 2011
VOLUME 6, NUMBER 2

THE JOURNAL OF **URGENT CARE** MEDICINE®

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LETTER FROM THE EDITOR-IN-CHIEF

Who's Steering This Ship?



As a young discipline and industry, urgent care relies heavily on its organizational leaders to advance the political, academic, and developmental agendas that are in the best interest of their constituents. These leaders represent the face and voice of their members on the national stage. Needless to say, we cannot become dependent on the work and vision of a few to dictate the direction and activity of the whole. Member engagement and participation are paramount to ensuring adequate representation and accountability.

Urgent care is a revolution of sorts, and revolutions are not fought by armchair infantries. If you care about the future of urgent care medicine, then get off your couch and join the fight! Being informed and involved is the best way to ensure proper stewardship.

So, to that end, it is with great pleasure that I dedicate this month's column to the introduction of two key elected officials from your representative urgent care organizations:

Marc Salzberg, MD, FACEP, was elected president of the Urgent Care Association of America (UCAOA) in May 2011, after serving two terms on its board of directors. Marc brings a wealth of organizational leadership experience with him to this critical position. As a formative leader of the specialty of emergency medicine, Marc started several of the first academic departments and residency training programs. Additionally, he championed emergency medicine as a uniquely critical health care delivery network that changed the way patients access acute care services and changed the quality of care they subsequently received.

Dr. Salzberg is a seasoned change manager, uniquely capable of moving bureaucratic barges in new directions. As president of UCAOA, Marc has made a commitment to "working with all stakeholders—insurance companies, hospitals, professional societies, governmental agencies, and private physician groups—to provide the best care in the most cost efficient manner to our patients."

Will Gluckman, DO, MBA, FACEP, was recently elected president of the newly formed Urgent Care College of Physicians (UCCOP). The physician college was born out of a need for a physician-led society to represent the clinical, research, educational, and specialty development agenda for the discipline

of urgent care medicine. No one is better suited than Will to lead the effort.

Dr. Gluckman concurrently serves on the UCAOA board of directors, giving him an important insight into the need for parallel agendas as we begin the natural separation of trade and specialty. Dr. Gluckman brings years of academic and team-building experience to this critical post. Will is committed to providing a national voice for the physicians who practice urgent care medicine. His support of specialty development initiatives such as the fellowship programs, clinical research, and *JUCM*, *The Journal of Urgent Care Medicine* reflects his critical understanding of the importance of such initiatives in securing a seat in the house of medicine. Will is a proven peace-keeper, capable of managing the potentially thorny relationships with our family and emergency medicine colleagues.

As organizations grow, change becomes more difficult, but no less important. Urgent care is at a critical stage of growth that will require forward-thinking, innovative leaders to create a roadmap for future success. Stagnation is simply not an option. These young organizations are not on cruise control and require a collective wave of energy to be impactful. Their respective leaders can only do so much yet must nevertheless be responsive to the needs of their members. So spend some time getting to know your organizations, their history, their achievements, how they function, how they are governed, and who their elected leaders are. Then give yourself an educated voice on the issues that matter most to you. Participate in meetings, chat in their online forums, or send an email to these newly elected officials.

Make sure your voice is heard, but don't stop there. Make a commitment to be part of the revolution. Join the fight and make a difference for the future of the discipline. ■

Lee A. Resnick, MD
Editor-in-Chief
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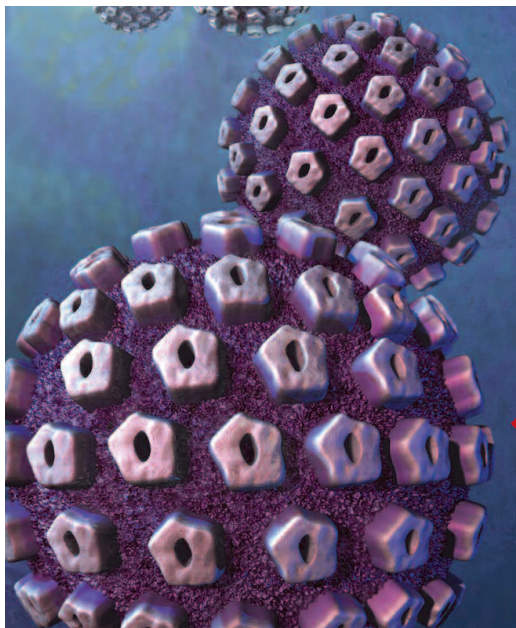
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November 2011

VOLUME 6, NUMBER 2



CLINICAL

9 STDs: Assessment and Treatment in Urgent Care

The patients most prone to sexually transmitted diseases are also most likely not to have a primary doctor. Many will turn to urgent care for help.

Thomas Sunshine, MD, FACOG

Illustration of the human papillomavirus (HPV) on a cellular background.

PRACTICE MANAGEMENT

19 A Better Way to Settle Malpractice Suits?

Mediation could produce better outcomes than litigation both for patients and the physicians they sue—if doctors would only show up.

Carol B. Liebman, JD



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Ira Pasternack

IN THE NEXT ISSUE OF JUCM

"Altered mental status," a not uncommon complaint in urgent care today, may include impaired cognition, attention, awareness, and level of consciousness. As tens of millions of baby boomers enter their 60s and 70s, cases of senile dementia, delirium, and psychosis are apt to become even more common in your practice. Here is how to assess and manage these patients.

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Case Western Reserve University
Department of Family Medicine
Institute of Urgent Care Medicine

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JUCM

EDITOR-IN-CHIEF

Lee A. Resnick, MD
editor@jucm.com

EDITOR

Neil Chesanow
nchesanow@jucm.com

CONTRIBUTING EDITORS

Nahum Kovalski, BSc, MDCM
John Shufeldt, MD, JD, MBA, FACEP
David Stern, MD, CPC

ART DIRECTOR

Tom DePrenda
tdeprenda@jucm.com



65 North Franklin Turnpike, Second Floor,
Ramsey NJ 07446

PUBLISHERS

Peter Murphy
pmurphy@braveheart-group.com
(201) 529-4020

Stuart Williams
swilliams@braveheart-group.com
(201) 529-4004

Classified and Recruitment Advertising

Russell Johns Associates, LLC
jucm@russelljohns.com
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Mission Statement

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

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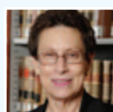
The Centers for Disease Control and Prevention estimates that there are 19 million cases of sexually transmitted disease or infection (STD/I) a year. Many will go undetected or unreported. For example, in 2009, the latest year for which statistics are available, there were about 1.5 million actual reported cases of chlamydia and gonorrhea. Yet 2006-2007 CDC data showed roughly 6 million ambulatory care visits "for unspecified viral and chlamydial infection" alone.

As Thomas Sunshine, MD, FACOG, points out in his cover article this month, it is estimated that almost half of the new STD/I's will be in the 15-24-year-old age group, and these individuals are among those likely not to have a regular primary care physician. "As urgent care providers, we are therefore in a unique position to be the first to encounter many such patients," he writes, "and a fundamental understanding of symptoms, testing processes, risk factors, treatments, and counseling are important."



To that end, Dr. Sunshine discusses human papilloma virus, herpes, viral hepatitis (A, B, and C), human immunodeficiency virus, gonorrhea, chlamydia, syphilis, and other sexually transmitted infections (trichomonas, scabies, lice, and molluscum contagiosum), with special emphasis on patient ignorance and counseling. For instance, about 40% of people infected with the hepatitis B virus are unaware of it, up to 80% of women and 10% of men with neisseria gonorrhea may be asymptomatic, and many people with herpes do not realize there is no cure.

Dr. Sunshine, originally trained as an OB/GYN, now works as a full-time urgent care physician at the Anderson, South Carolina, office for DoctorsCare, providing both urgent and primary care. His last article for JUCM was "Assessing Abnormal Intrauterine Bleeding" in the April 2010 issue.



Is litigation the best way to settle a malpractice suit? Maybe not. In our practice management article this month, "A Better Way to Settle Malpractice Suits," Legal scholar Carol B. Lieberman, JD, argues that mediation offers a better result to both patients who were harmed and doctors who are being sued.

Professor Lieberman and a colleague studied the results of 31 mediations of cases from 11 nonprofit hospitals in New York City that were referred to mediation in 2006 and 2007. The cases included claims for failure to diagnose, surgical error, failure to treat, inadequate care, improper treatment, and medication error. Just over 70% of the cases were resolved either during or after mediation. Both defense and plaintiff attorneys had positive reactions to the process, as did hospital representatives, insurers, and patients or their surviving family members. Whether the doctors involved felt the same is unknown, writes Professor Lieberman ruefully; not a single physician took part. She makes a persuasive case that this should change.

Professor Lieberman is a Clinical Professor of Law at Columbia Law School in New York.



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Also in this issue:

John Shufeldt, MD, JD, MBA, FACEP, channels Sir William Osler, the renowned Johns Hopkins pathologist and physician, who has been called the "father of modern medicine," for a meditation on the two most important traits a physician can possess: *aequanimitas* (Latin for equanimity) and imperturbability. Including excerpts from Osler's valedictory address to medical students at the University of Pennsylvania, Dr. Shufeldt relates these two cardinal virtues to the practice of urgent care medicine with his usual keen insights, wit, and humor.

Nahum Kovalski, BSc, MDCM, reviews new abstracts on current literature germane to the urgent care clinician, including the effectiveness of Chinese herbs for treatment of influenza; cranberries vs TMP-SMX for treatment of urinary tract infection (UTI), Holter monitoring in octogenarians with syncope; new AAP guidelines for diagnosis and management of febrile UTI in infants and young children; the first guidelines for management of pediatric community-acquired pneumonia; influenza vaccination in the US, 2011-2012; an FDA warning of abnormal heart rhythms with Zofran (ondansetron); lack of durability in pertussis vaccination; the lack of utility of lab testing in patients with chronic urticaria; and

the clinical and economic benefits of tailoring treatment of low back pain to the patient.

In Coding Q&A, **David Stern, MD, CPC**, fields reader questions, including problems with an EHR that fails to code nebulizer treatments correctly; the HCPCS code to use for diltiazem IV; whether an E/M code could be added to a patient visit and a copay collected if a doctor personally checks each pediatric patient prior to giving an influenza vaccine; and how to code an urgent care visit for chest pain with hypertension for nitroglycerin monitoring with serial VS monitoring, ECGs, and stabilization of the patient.

Our Developing Data end piece this month looks at urgent care marketing and advertising, from newspaper ads, to Yellow Pages ads, to Internet banners, to billboard ads, and how much money urgent cares are investing in these efforts. While nearly half of urgent cares invest in Internet and/or paid-search ads, for instance, there are many additional marketing opportunities online for clinics that offer website visitors health information on diseases and conditions, as well as details about services and procedures that go beyond mere listings. For details, see "Attract More Patients to Your Website—and to Your Urgent Care" posted on the JUCM website. ■

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FROM THE EXECUTIVE DIRECTOR

Meet Our First Urgent Care Management Certificate Recipient

■ LOU ELLEN HORWITZ, MA

Carlene Cox is the Clinical Manager for Genesis FirstCare, the urgent care service offered by the Genesis HealthCare System in Zanesville, Ohio. She's also a UCAOA celebrity because she is the first person to have completed the Urgent Care Management Certificate (UCMC).

The UCMC program is a 40-hour educational program designed to improve and recognize proficiency in the core competencies of center management. We launched it in April—Carlene was done by August.

In September, I was privileged to talk with Carlene about why an already successful urgent care manager would pursue the UCMC, how she did it so quickly, and why she thought it was a good use of her very limited time.

Carlene Cox is the kind of person we love to get in urgent care—smart, driven, a natural over-achiever, and aware of the value she and her team bring to the community. Genesis FirstCare is fairly new—opening in 2006—but Carlene had been working for Genesis long before that.

She started at Genesis as a laboratory technician with an associate's degree. After a few years, she saw an opportunity to increase marketing of lab services to businesses in her community. Her idea took off like a rocket, and shortly thereafter she went back to school (while working full time) to obtain a degree in healthcare management.

Genesis's expanding relationship with businesses naturally grew into an occupational health program, which Carlene has managed since 1991. Along the way, she picked up the Certificate of Competency in Occupational Health Practice Management from our colleagues at the National Association of Occupational Health Professionals (NAOHP). When Genesis opened its two urgent care centers, Carlene was the natural choice to manage them.



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

When Carlene saw the announcement for the UCMC program she said, "It just seemed like a logical next step in my career. I hadn't been in urgent care that long—only 4 years—and I felt this would be an excellent opportunity to increase my skills."

As to her quick completion of the program, Carlene said, "I have to admit, I was hesitant at first. I wasn't sure if I would have enough time to do it all. We were implementing an EMR at the same time, so I was nervous about the commitment. With the support of my colleagues, I decided to set aside time on Fridays to complete it. It was so easy to use. I was amazed at how quickly I was able to get it all done."

Carlene also took advantage of the program as an impetus to use the access she already had to UCAOA content. "I had been to the last convention, and even though I could have taken tests on the sessions I'd seen there, I decided to take all new sessions instead. It was a great value because they were already paid for with my convention registration. That made the entire program a very easy sell to my organization because it was so cost-effective."

Genesis covered Carlene's registration fees for the program, and the physician practice group that staffs the urgent care center was also very supportive. "The support I received reinforced to the entire team that Genesis recognizes the value of the services we provide and is willing to invest in making it even better. It gave them added confidence in me, too, because they know that I am current in the field of urgent care."

When asked what she would tell other managers, Carlene said, "Don't let your initial hesitancy keep you from doing this. Recognize that we have a special niche, and it's our responsibility to stay knowledgeable about our niche. If you can set aside a set time for it, it's really convenient and, of course, informative. It also says to your staff that you believe in ongoing growth and development."

I'd say Carlene Cox is someone to watch. If you want to find her, she says to let you know she's on UConnect (<http://uconnect.ucaoa.org/home>) and loves connecting with her fellow urgent care professionals. ■



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STDs: Assessment and Treatment in Urgent Care

Urgent message: The patients most prone to sexually transmitted diseases are also mostly likely not to have a primary doctor. Many will turn to urgent care for help.

THOMAS SUNSHINE, MD, FACOG

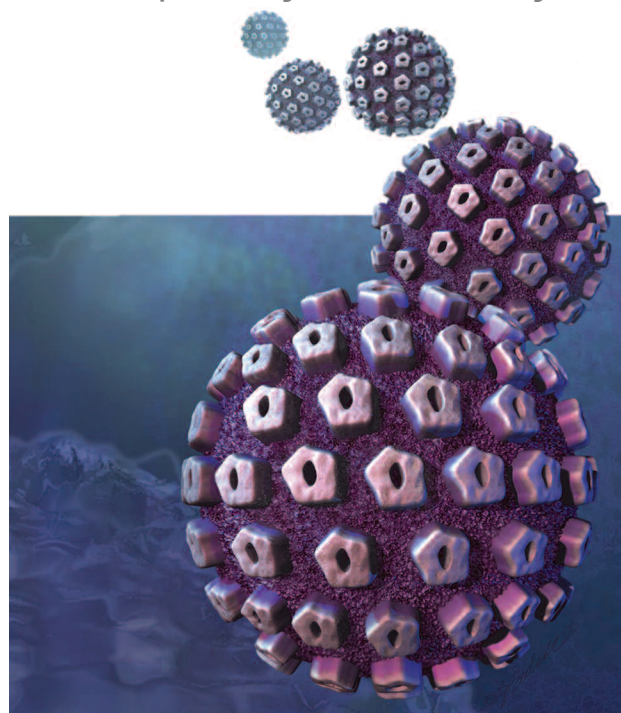
As urgent care physicians, we often are presented with patients who are worried that they may have a sexually transmitted disease or infection (STD/I). The number of yearly visits is difficult to estimate because the diagnosis codes of the visits vary. The Center for Disease Control's (CDC) surveillance data estimates that there are 19 million new cases of STD/I yearly; many will go undetected or unreported.¹ In 2009, the latest year for which statistics are available, there were about 1.5 million actual reported cases of chlamydia and gonorrhea. The 2006-2007 CDC data for the diagnosis group "unspecified viral and chlamydial infection" showed roughly 6 million ambulatory care visits.

It is estimated that almost half of new STD/I cases will be in the 15-24-year-old age group, individuals who may not have an established primary care provider. As urgent care providers, we are therefore in the unique position to be the first to encounter many such patients, and a fundamental understanding of symptoms, testing processes, risk factors, treatments, and counseling are important. There is no formal categorization of what is included in a STD/I screening. This article focuses on specific infections that are important in urgent care.

Clinical Approach

The key components of the history include assessing the

Thomas Sunshine, originally trained as an OB/GYN, now works as a full-time urgent care physician at the Anderson, South Carolina, office for DoctorsCare, providing both urgent and primary care. His last article for JUCM was "Assessing Abnormal Intrauterine Bleeding in the Urgent Care Center" (April 2010).



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patient's risk factors for STD/I exposure (**Table 1**). Do not assume heterosexual, homosexual, or bisexual contact. Simply ask. Explain that this is an universal approach and although occasionally awkward, it avoids having to make judgments about the patient's sexual preferences.

A patient may not recognize prior symptoms as being indicative of the presence of an STD/I. An ulceration or sore area is often assumed by the patient to be an ingrown hair or associated with shaving. It is also common to hear a condyloma referred to as a skin tag. HPV infection may also be inferred from a female partner with a history of abnormal pap smears. Sore areas in the groin may represent adenopathy but may have been thought to be pulled muscles. Any unexplained sys-

Table 1. Risk Factors for STD/1 Exposure

- Unprotected sex
- Multiple partners
- Early age of intercourse (<25 of age)
- Sex with members of high-risk groups
- Excessive use of alcohol or substances that impair judgment
- Prior or current STD

Source

Centers for Disease Control and Prevention. *Program Operations: Guidelines for STD Prevention: Community and Individual Behavior Change Interventions*. CDC website. Available at: www.cdc.gov/std/program/community.pdf. Accessed September 27, 2011.

temic illness should also be investigated, with special attention paid to unexplained rashes and hepatic or genitourinary symptoms.

The standard general physical exam, including the genitalia, will usually suffice. Pay special attention to evidence of current rashes, jaundice, adenopathy, hepatic enlargement, abdominal tenderness, or skin ulcerations. In order to be prepared for specific testing during the genital exam, it is helpful to have the discussion ahead of time regarding which specific tests could be performed. Educating the patient about potential infections and their testing processes often takes some time. After this review, for financial reasons, the patient may only wish to test for certain infections. Cost-effective testing is important in the urgent care setting, as we are often faced with self-pay patients or those with high out-of-pocket coverage. Some tests take weeks to months to show evidence of infection, so follow up instruction should be documented.

An in-depth review of each infection and advanced treatments are beyond the scope of this article. The information provided here is intended to allow an informative discussion with patients and meet their need for STD screening, treatment choices, and counseling. The testing processes described are commonly used, but individual urgent cares should consult with their laboratories to learn what is recommended.

Human Papilloma Virus

There roughly 150 viral subtypes of human papilloma virus (HPV) causing human infection; about 40 subtypes are associated with the anogenital infection. Classification is based on their oncogenic potential. The low-risk subtypes cause condyloma (warts) and are not associated with the development of cancer. High-risk subtypes are associated with the development of cancer.

The natural history of this progression is complex and not fully understood. In fact, 80%-90% of infections

Table 2. Human Papillomavirus Treatments**Office**

- Podophyllin 10%-25%
- Trichloroacetic or bichloroacetic acid
- Cryotherapy, laser therapy, cautery

Prescription

- Podofilox 0.5%
- Imiquimod 5%
- Sinecatechins 15%

Source

Centers for Disease Control and Prevention. *Sexually Transmitted Diseases: Treatment Guidelines, 2010: Genital Warts*. CDC website. Available at: www.cdc.gov/std/treatment/2010/genital-warts.htm. Accessed September 27, 2011.

Table 3. Human Papillomavirus Recombinant Vaccines**Gardasil®**

- Vaccine for types 6, 11, 16, and 18
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Cervarix®

- Vaccine for types 16 and 18
- Approved for females ages 9-25 years of age

Source

Centers for Disease Control and Prevention. *Sexually transmitted diseases: treatment guidelines, 2010: genital warts*. CDC website. Available at: www.cdc.gov/std/treatment/2010/genital-warts.htm. Accessed September 27, 2011.

may resolve on their own.² No reporting process is formally established for HPV infections. The CDC estimates that about 20 million people are infected with a high-risk subtype of HPV (primarily type 16 or 18), with 6 million new cases a year. A National Cancer Institute study, pre-vaccine era, reported a prevalence of 27% in women ages 14-59 years old, with almost 45% in women ages 14-19.³ Surveillance data suggest an overall HPV prevalence of 23% of the high-risk subtypes and range from 35% in women aged 14-19 years of age to 6% in women 50-65 years of age.⁴ Such information emphasizes the widespread nature of HPV infection, with an estimated 357,000 annual office visits.⁵

The testing process for HPV involves collection of cervical cells, often at the time of a pap smear, which are analyzed for HPV DNA. Routine HPV testing is not generally recommended for screening but is performed reflexively if pap smear results justify it. If warranted, pap smear and HPV testing can be done as part of the STD/I exam. HPV infection can be latent, meaning



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Table 4. Treatment for Genital Herpes

First Clinical Episode
<ul style="list-style-type: none"> • Acyclovir 400 mg PO tid x 7-10 days or • Acyclovir 200 mg PO 5 times/24 hours x 7-10 days or • Famciclovir 250 mg PO tid x 7-10 days or • Valacyclovir 1000 mg PO bid x 7-10 days
Source Centers for Disease Control and Prevention. Sexually transmitted diseases: treatment guidelines, 2010: diseases characterized by genital, anal, or perianal ulcers. CDC website. Available at: www.cdc.gov/std/treatment/2010/genital-ulcers.htm#hsv . Accessed September 27, 2011.

there is cellular infection but viral amounts are so small that no skin changes have occurred and testing may not even detect their presence.⁶ Screening for HPV DNA is not indicated for males. In the absence of visible lesions, penile “colposcopy” (using 3%-5% acetic acid) can be performed, although this controversial. Since HPV can be latent or subclinical, a positive test result does not imply recent infection.

Treatment for HPV infections involves removal of visible condylomatous warts and an assessment of oncologic changes. Patients may receive prescription management or treatment in urgent care, depending on provider training (**Table 2**). More aggressive treatments involve excision, laser therapy, or interferon injections. Appropriate patients should be offered vaccination (**Table 3**).

Herpes

Herpes Simplex virus (HSV) type 1 is generally considered to cause outbreaks of the face and lip and type 2 of the genital region. But as a result of sexual practices, considerable overlap exists and either virus can be found at either site. Following initial infection, either virus establishes latency in either the trigeminal or sacral ganglia.

As with HPV, no specific reporting requirement exists for infection with HSV. However, it has been estimated that in 2009, there were about 300,000 initial outpatient visits for genital herpes.⁵ Based on antibody seropositivity, it is estimated that 50% of teens are positive for HSV 1, and the rate goes up to 85% by age 50 years. For HSV 2, in 14-49-year-olds, positivity is 16%. Similarly, 19% of people report a history of genital herpes based on survey reports rather than antibody titers. Contributing to such high infection rates are asymptomatic shedding rates of 5%-10% for both types 1 and 2.⁷

The high prevalence rates and often subclinical nature

of the disease makes the decision to test for HSV in the urgent care setting a dilemma. Some patients will want to know if a certain sexual encounter infected them with HSV. In addition, many people do not realize there is no cure, just treatments to reduce the frequency of outbreaks or speed their healing. Data currently reflects that early treatment with an antiviral after initial exposure limits the viral amount eventually found in the ganglia, but it does not prevent disease. These are important issues to discuss with the patient presenting for STD testing who has no appreciable lesion. With a lesion present, the patient may be satisfied with a diagnosis by experienced visual inspection, but other STD/I's can also cause ulcerations.

HSV immunoglobulin (Ig) M is positive at 7-10 days, and IgG becomes positive, depending on the test, as soon as 3-4 weeks. Because recurrent infection can elevate IgM as well, this nullifies IgM's usefulness as an indicator of primary infection. A potentially predictive testing process would be an initial, negative, type-specific IgG that subsequently turns positive. It is important the patient has a clear understanding of the limitations of the testing process and results before proceeding. The clinician can do a viral culture on an open sore. The usefulness of a culture once a lesion is healing is limited. Also, a sample from the lesion may detect the presence of viral DNA using a process called “polymerase chain reaction.” CDC treatment guidelines are reviewed in **Table 4**.

Viral Hepatitis

It is important to consider screening for viral hepatitis in any STD/I visit. The important viral types in the United States are hepatitis A (HAV), B (HBV), and C (HCV). Viral types D and E are more prevalent in other parts of the world. Of these types, only HAV is passed via a fecal/oral route. The others are passed primarily by infected body fluids, which, in the context of STD/I screening, means semen and vaginal fluids, although percutaneous spread of infected blood is by far the most common route. The prevalence of these infections is recorded annually, based on voluntary reporting. It is thought that there is significant under-reporting.

Hepatitis A

In 2009, the CDC estimates there were 21,000 new cases of HAV infection. Considering the route of transmission, only certain sexual practices will pass this virus. Gastrointestinal and hepatic symptoms begin roughly 2-6 weeks following infection and are generally self-limited. Some people will have symptoms longer. HAV vaccination is

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Table 5. Interpreting Hepatitis Serology

Tests	Results	Interpretation
<ul style="list-style-type: none"> • HBsAg • Anti-HBc • Anti-HBs 	Negative Negative Negative	Susceptible
<ul style="list-style-type: none"> • HBsAg • Anti-HBc • Anti-HBs 	Negative Positive Positive	Immune due to natural infection
<ul style="list-style-type: none"> • HBsAg • Anti-HBc • Anti-HBs 	Negative Negative Positive	Immune due to Hepatitis B vaccination
<ul style="list-style-type: none"> • HBsAg • Anti-HBc • IgM anti-HBc • Anti-HBs 	Positive Positive Positive Negative	Acutely infected
<ul style="list-style-type: none"> • HBsAg • Anti-HBc • IgM anti-HBc • Anti-HBs 	Positive Positive Negative Negative	Chronically infected
Source Adapted from: Morbidity and Mortality Weekly Report (MMWR). A comprehensive immunization strategy to eliminate transmission of hepatitis B virus infection in the United States. Recommendations of the Advisory Committee on Immunization Practices (ACIP). Part I: immunization of infants, children, and adolescents. <i>MMWR Morb Mortal Wkly Rep.</i> 2005;54(RR-16):1-32.		

recommended for individuals of all ages over 1 year old.

Following a specific exposure, the CDC recommended in 2007 that HAV vaccine be given to prevent infection, preferably within 2 weeks of exposure, in patients between 1 and 40 years of age. After age 40 years, based on limited vaccine data, immune globulins are the only intervention to prevent disease. Routine pre-vaccination screening for immunity is only recommended for groups likely to already have immunity; this is for cost control rather than medical issues. STD screening therefore represents a good time to offer HAV vaccination, and this should be included in any counseling.

Hepatitis B

The annual number of new infections of HBV is much greater than with HAV, with an estimated 38,000 annual new infections. Because HBV can develop into a chronic infection, roughly 800,000 to 1.4 million persons are thought to be chronically infected in the US. It is difficult to know how many of those cases are from sexual contact, as about 40% of people don't know how or when they contracted the virus. Most individuals who have contracted the disease as an adult will recover and not become chronic carriers. Sexual trans-

mission occurs from HBV virus present in semen or vaginal fluids or from percutaneous blood exposure; HBV is highly infectious. The higher an individual's viral load, the higher the infectivity. The virus has been detected in saliva, tears, and urine, but these are not thought to be methods of transmission.

For an STD/I screening visit, the patient may present before the onset of gastrointestinal or hepatic symptoms, which begin an average of three months following exposure. The patient needs to know that he can be infectious weeks before developing any symptoms. If the patient has no specific history of vaccination, then vaccination should be initiated. (CDC treatment guidelines for hepatitis B are available at www.cdc.gov/std/treatment/2006/hepatitis-b.htm.) Beginning vaccination within the first 24 hours after contact may prevent infection. There is no contraindication to giving the vaccine if the patient has already been vaccinated, assuming no previous allergic reaction. Universal vaccination at birth was first recommended by the Advisory Committee on Immunization Practices (ACIP) in 1991. Apart from counseling and vaccination, should the patient or provider need to know actual HBV status, blood serology can be performed. **Table 5** provides a guide for interpretation of results.

Hepatitis C

HCV has the distinction of being the most common blood-borne infection in the US, with an estimated 3.2 million individuals currently infected. In 2009, however, only 16,000 people were thought to be newly infected; about 80% of them go on to become chronic carriers. HCV is substantially less infectious than HBV, making sexual transmission of HCV unlikely but not impossible. The CDC's *Morbidity and Mortality Weekly Report (MMWR)* reported that 10% of newly infected people identified an infected sexual partner as the probable source.⁸ However, a study over 10 years of 895 monogamous couples, in which one partner had HCV, identified no partner-to-partner transmission.⁹ There is no vaccination or prophylactic treatment available and thus no specific interventions at the urgent care level. Counseling should focus on risk factors before deciding whether serologic testing for HCV antibody is warranted for the patient's current status. Follow-up testing would depend on the development of hepatic (or other) symptoms in approximately three months.

Human Immunodeficiency Virus

Considering the vast amount of literature concerning

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Table 6. Treatment for Gonorrhea, Chlamydia, and Pelvic Inflammatory Disease

Uncomplicated Gonorrhea: Cervix, Urethra, or Rectum
<ul style="list-style-type: none"> Ceftriaxone 250 mg IM x 1 dose or Cefixime 400 mg PO x 1 or Injectable cephalosporin x 1 plus azithromycin 1 g PO x 1 or Doxycycline 100 mg PO bid x 7 days
Chlamydia
<ul style="list-style-type: none"> Azithromycin 1 gram PO x 1 or Doxycycline 100 mg PO bid x 7 days or either Erythromycin base 500 mg PO qid x 7 days Erythromycin ethylsuccinate 800 mg PO qid x 7 days Levofloxacin 500 mg PO qd x 7 days Oxofloxacin 300 mg PO bid x 7 days
Pelvic Inflammatory Disease: Outpatient Regimens
<ul style="list-style-type: none"> Ceftriaxone 250 mg IM x 1 dose plus doxycycline 100 mg PO bid x 14 days Cefoxitin 2 g IM with probenecid 1 g PO x 1 plus doxycycline 100 mg PO bid x 14 days with or without metronidazole 500 mg PO bid x 14 days Third generation cephalosporin IM plus doxycycline 100 mg PO bid x 14 days with or without metronidazole 500 mg PO bid x 14 days
Source Centers for Disease Control and Prevention. Sexually transmitted diseases: treatment guidelines, 2010. CDC website. Available at: www.cdc.gov/std/treatment/2010/default.htm . Accessed September 27, 2011.

HIV and its associated disease AIDS, it may be the patient's primary concern. The most recent CDC data (2009) estimated that 48,000 people were diagnosed with a new HIV infection in the US. There were about 1.1 million people with HIV infection and 20% were unaware of their infection.¹⁰ Fifty percent of new infections were from male-to-male sexual contact and 30% were from heterosexual contact. This data does not translate well into probabilities of transmission from a single contact, as other factors—such as type of sexual practice, sex of the infected partner and the partner's viral load, and presence of coexistent diseases—all impact the risk.¹¹

Following an exposure to HIV, antibodies can develop as early as two weeks and in most patients by three months. Rapid, qualitative HIV antibody testing can be performed on blood or oral fluid in a Clinical Laboratory

Improvement Amendments (CLIA)-waived laboratory in an urgent care. Any positive results from this immunoassay testing should be confirmed by the Western blot method before telling the patient of a confirmed diagnosis for HIV infection. If the patient tests negative, the provider should consider whether post-exposure prophylaxis (PEP) should be initiated. PEP should be initiated within 72 hours after high-risk exposure, such as sex with a known carrier of HIV. With unknown partner status or presentation greater than 72 hours, there are no specific recommendations for PEP.

Gonorrhea

Neisseria gonorrhea (NG) is the second-most-commonly-reported STD/I in the US, with 301,000 actual reports and 700,000 estimated infections occurring in 2009.

NG generally infects the genital tract, but be alert for infection of the rectum, eyes, oropharynx, skin, or joints. Following exposure, the chance of being infected from heterosexual sexual contact ranges from 20% if the infected partner is female to up to 70% if the infected partner is male.^{12,13} Patients can develop genitourinary symptoms as early as two to five days, although men may take up to one month. The patient is infectious all this time. Up to 80% of women and 10% of men may be asymptomatic.¹³

Testing for NG is conducted by swabbing the site of infection and performing either a nucleic acid amplification test (NAAT), culture, or gram stain. Many centers prefer to do NAAT on a urine specimen for genitourinary infection. (Urine testing for NG in women is not very sensitive, although it is a reasonable option for men.) The associated laboratory may not recommend NAAT on rectal, pharyngeal, or conjunctival swabs. When antibiotic sensitivity information is necessary, a culture should be performed. If a center provider has the appropriate ability, a gram stain from any infected sites to check for gram-negative diplococci can be performed, but this will have its primary diagnostic value for male urethral discharge.

Current treatment is specified by the CDC, as well as by regional antibiotic resistance data; the latter is available from local health departments. Due to the high rates of co-infection with chlamydia, an antibiotic regimen that treats both sexual partners is advocated. The most recent 2010 CDC recommendations for treatment are shown in **Table 6**. The CDC recommends that patients with a severe penicillin allergy have a consultation with an infectious disease specialist and may receive a single dose of 2 grams of azithromycin.

Chlamydia

Infection with chlamydia trachomatis is the most common bacterial STD/I reported to the CDC, with 1,244,000 infections in 2009, with an estimated number of over 2.8 million infections annually. The rates of chlamydia infection in 15-24-year-olds ranges from 3.5% (Vermont) to 13.7% (Mississippi). This younger group has three times the rates of 25-49-year-olds. The most common symptoms are genitourinary, although chlamydia can infect the oropharynx, eyes, or rectum as well. Symptoms may occur as early as one week; however, up to two-thirds of women and one-half of men may not have symptoms.

A chlamydia test should be part of any STD/I screen whether a specific exposure can be identified or not. Universal screening is recommended for all sexually active females under age 25. NAAT can be performed on urine or with a cervical or urethral swab. NAAT testing methods are generally preferred in the urgent care setting and are done in conjunction with NG testing. Some laboratories can use liquid-based cytology specimens used for pap smears for NAAT testing as well.

Syphilis

Caused by the spirochete, *Treponema pallidum*, syphilis is part of any STD/I evaluation. Of 44,800 total cases in 2009, about 30,000 were diagnosed serologically, while in a latent stage. About two-thirds of the cases were reported from the male homosexual population. Symptoms, when occurring, appear primarily as painless chancres or secondarily as generalized symptoms affecting almost any body system. Systemic symptoms range from a non-pruritic rash, arthralgias, myalgias, and adenopathy to complications of the heart and central nervous system. The primary chancre develops in an average of three weeks after exposure; secondary symptoms may occur in about four weeks. The spirochete creates an endarteritis by binding to endothelial cells, which then release a reagin.

Two types of tests for syphilis are available: non-treponemal and treponemal. Because of ease, most screenings are done with rapid plasma regain (RPR), which tests for reagin in blood. Alternatively, a venereal disease research laboratory (VDRL) test can be performed. As these do not



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Table 7. Other Sexually Transmitted Infections

Infection	Description	Symptoms	Tests	Treatment
Trichomonas	<ul style="list-style-type: none"> • <i>Trichomonas vaginalis</i> • Anaerobic, flagellated protozoan 	<ul style="list-style-type: none"> • Yellow-green vaginal discharge, odor • Itching (female) • Dysuria (male) 	<ul style="list-style-type: none"> • Wet prep • Rapid test • Culture 	<ul style="list-style-type: none"> • Metronidazole 2 g PO
Scabies	<ul style="list-style-type: none"> • <i>Sarcoptes scabiei</i> • Mite (arthropod) 	<ul style="list-style-type: none"> • Intense itching • Superficial burrows 	<ul style="list-style-type: none"> • Clinically 	<ul style="list-style-type: none"> • Permethrin cream 5% • Crothamiton 10% lotion or cream
Lice	<ul style="list-style-type: none"> • <i>Phthirus pubis</i> • Ectoparasite, louse 	<ul style="list-style-type: none"> • Itching • Visible nits or lice 	<ul style="list-style-type: none"> • Clinically 	<ul style="list-style-type: none"> • Permethrin 1% lotion
Molluscum Contagiosum	<ul style="list-style-type: none"> • Molluscum contagiosum DNA poxvirus 	<ul style="list-style-type: none"> • 1-5 mm dimpled growth 	<ul style="list-style-type: none"> • Clinically 	<ul style="list-style-type: none"> • Self-limited in healthy individuals; treatment may be unnecessary • Cryotherapy, curettage, or laser therapy • Oral cimetidine (small children) • Podophyllotoxin cream (0.5%) (men; not recommended for pregnant women)

SourcesCenters for Disease Control and Prevention. Sexually Transmitted Diseases (STDs). Available at: www.cdc.gov/std. Accessed September 27, 2011.Centers for Disease Control and Prevention. Molluscum (Molluscum Contagiosum). Available at: www.cdc.gov/ncidod/dvrd/molluscum. Accessed September 27, 2011.

test for the actual spirochete, and have many false positives, a positive test should be confirmed by a treponemal test, either a fluorescent treponemal antibody–absorbed (FTA–abs) or a microhemagglutination assay–*T. pallidum* (MHA–TP). Treatment for primary, secondary, and early-latent syphilis is benzathine penicillin G 2.4 million units IM x 1. Late latent syphilis requires three doses of 2.4 million units IM one week apart. Full treatment and follow-up may require referral. Bicillin® L-A, not Bicillin® C-R, is the recommended product.

Other Considerations

Other infections—trichomonas, scabies, lice, and molluscum contagiosum—can be transmitted from sexual or skin contact (**Table 7**). If indicated, emergency contraception should be addressed.

Conclusion

Many patients with an STD/I are likely to show up in urgent care. Unexplained rashes, jaundice, adenopathy, hepatic enlargement, abdominal tenderness, skin ulcerations, genitourinary symptoms, or systemic illness should be investigated. Follow-up instructions should be documented. Educating the patient about STDs is essential. ■

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Practice Management

A Better Way to Settle Malpractice Suits?

Urgent message: Mediation could produce better outcomes than litigation for patients and physicians—if doctors would only show up.

CAROL B. LIEBMAN, JD

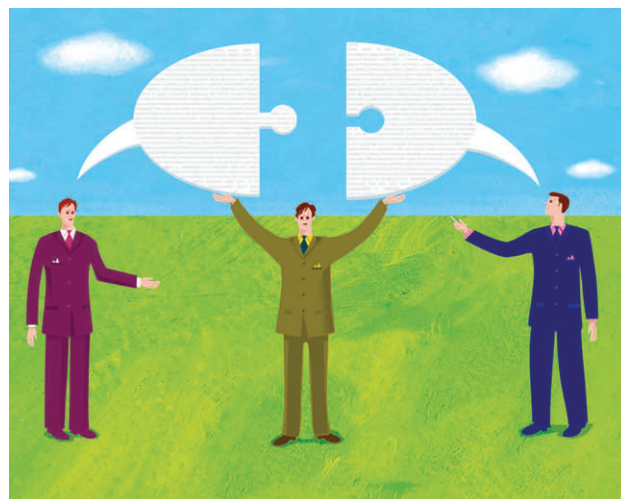
Introduction

- A stomach pain is misdiagnosed as viral gastroenteritis. The patient ends up in the hospital for six days with complications from a ruptured appendix.
- A physician prescribes penicillin to a woman with clearly documented allergies, which leads to anaphylaxis and a day in the ICU.
- A severe headache is labeled a migraine; the patient dies the next day from a ruptured cerebral aneurysm.
- A young person with chest pain is told he has costochondritis, but the pain, in fact, was caused by a pulmonary embolism.

Too often, as both the Institute of Medicine and Harvard Medical Practice Study have documented, patients are harmed by medical care intended to help. Sometimes that harm is the result of an unpreventable event; at other times, it is the result of error. Often, especially when communications break down, the result is a lawsuit.

A colleague, Chris Stern Hyman, and I have been involved in research testing whether mediation—a process in which parties to a dispute are assisted in resolving their conflict by an impartial third party—offers a better forum than litigation for resolving medical malpractice cases. We found that mediation can lead to a quicker, less costly, and more satisfying resolution than the adversarial litigation system.

Mediation can also offer emotional relief to plaintiffs by giving them an opportunity to be heard and to ask questions. And mediation can help urgent care centers



and hospitals discover ways in which procedures might be changed to prevent recurrences of the error that sparked the lawsuit.

Too often, however, that potential goes unrealized because of the failure of physicians to participate in the mediation process.

A Revealing Study

Our study, “Interest-Based Mediation of Medical Malpractice Lawsuits: A Route to Improved Patient Safety,”¹ looked at the results of 31 mediations of cases from 11 nonprofit hospitals in New York City that were referred to mediation in 2006 and 2007. The cases included claims for failure to diagnose, surgical error, failure to treat, inadequate care, improper treatment, and medication error. Just over 70% of the cases were resolved either during or after mediation, resulting in monetary

Carol B. Liebman is a Clinical Professor of Law at Columbia Law School in New York. This article is based on original research that was published in the *Journal of Health Politics, Policy and Law* in October 2010.

settlements of \$35,000-\$1.7 million. Possible changes in hospitals' practices or policies to improve patient safety were identified in four cases.

While defense lawyers were less likely to agree to mediation than were plaintiffs' lawyers, both groups of attorneys had positive reactions to participation in the mediation process, as did hospital representatives and insurers. Plaintiffs—either the injured patient or surviving family members—attended 25 of the 31 mediations and also gave their experience in mediation a positive rating.

We were unable to determine physician reaction to the mediation process since not a single physician attended a mediation.

What Is Mediation?

Mediation is a process in which a neutral party tries to help people in conflict (or, sometimes, those trying to make a deal) work out their differences and reach an agreement that meets the needs of all. Unlike a judge or arbitrator, mediators do not decide who is right or wrong or tell the participants what they should do. Instead they facilitate a discussion among those at the table, helping them consider options for resolving the dispute.

Mediation is both voluntary and confidential. It is voluntary in the sense that, even when parties are required to mediate by courts or by a prior agreement, they are not required to reach an agreement and can end the mediation at any time. It is confidential in that what is said by participants during the mediation cannot (with very few exceptions) be used in any subsequent judicial or administrative proceeding. Because mediation communications are confidential, participants can offer information, explanations and, when appropriate, apologies without fear that what they say will be turned against them should the case go to trial.

Benefits of Mediation

Mediation is generally recognized as offering a number of benefits: quicker, less expensive resolution; fair compensation provided relatively soon after harm when it may be most needed by the plaintiffs; control of decision making by the litigants and their lawyers rather than judges; the opportunity to discuss all issues important to the parties, not just those relevant to their legal claims; the chance to repair relationships; avoidance of some, if

“Mediation can lead to a quicker, less costly, and more satisfying resolution than the adversarial litigation system.”

not all, of the emotional and financial costs of litigation; and, as already mentioned, the ability to speak in a less-guarded way.

In the healthcare setting, mediation offers a number of special, additional benefits. Patients and families may, for the first time, learn exactly what happened to cause the harm. They may gain a greater understanding of the complexity and uncertainty of medical care.

Hospitals and healthcare providers may learn about missed or ignored information that contributed to the harm, which may help avoid the re-occurrence of the error in the future.

But many of those benefits will not be realized unless physicians become full participants in the process.

The Mediation Process

Typically the mediator will begin the mediation by explaining the process, the mediator's role, and the role of the patient, family, doctors, and lawyers involved. The mediator then gives each participant an opportunity to explain his or her concerns and perspective on the problem. The initial statements of the parties and their lawyers are followed with information exchange and, ultimately, by discussions about both financial and non-economic options for resolution. Research shows that provisions for an apology (though when error is clear, one would hope that the patient would not have to wait until the mediation to receive an apology), continued care at no cost, a “memorial lecture” (ie, a lecture, generally annual, in a deceased patient's name, that the doctor would endow), or some other way to give meaning to a loss, may be especially important to the plaintiff and the family.

Mediators differ in their philosophies, the techniques they use during the mediation, and what they see as the goals of the process. Facilitative, interest-based mediators see their role as ensuring that all participants in the mediation process have the opportunity to speak, provide information, ask questions, and have their feelings and their concerns—including those that are not relevant to the legal claim—addressed. Facilitative mediators help the participants shape, evaluate, and reach an agreement. They do not make decisions for the parties.

Evaluative mediators tend to focus the discussion on facts relevant to the legal case, often make predictions about likely outcomes in court, ignore feelings, and

with reduced creatinine clearance will have diminished clearance of the drug. SPRIX® is contraindicated in patients with advanced renal impairment. Patients treated with SPRIX® should be adequately hydrated. Use SPRIX® with caution in patients with impaired renal function, heart failure, liver dysfunction, those taking diuretics or ACE inhibitors, and the elderly. Long-term administration of NSAIDs has resulted in renal papillary necrosis and other renal injury such as interstitial nephritis and nephrotic syndrome.

Anaphylactoid Reactions. As with other NSAIDs, anaphylactoid reactions may occur in patients with or without a history of allergic reactions to aspirin or NSAIDs and in patients without known prior exposure to ketorolac. SPRIX® should not be given to patients with the aspirin triad.

Cardiovascular Effects

• Cardiovascular (CV) Thrombotic Events

Clinical trials of several COX-2 selective and nonselective NSAIDs of up to three years duration have shown an increased risk of serious CV thrombotic events, myocardial infarction and stroke, which can be fatal. Patients with known CV disease or risk factors for CV disease may be at greater risk. To minimize the potential risk for an adverse CV event in patients treated with an NSAID, the lowest effective dose should be used for the shortest duration possible.

• Hypertension

NSAIDs can lead to onset of new hypertension or worsening of preexisting hypertension, either of which may contribute to the increased incidence of CV events. Patients taking thiazides or loop diuretics may have impaired response to these therapies when taking NSAIDs.

• Congestive Heart Failure and Edema

Fluid retention, edema, retention of NaCl, oliguria, and elevations of serum urea nitrogen and creatinine have been reported in clinical trials with ketorolac. Therefore, only use SPRIX® very cautiously in patients with cardiac decompensation or similar conditions.

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

Pregnancy. Starting at 30 weeks gestation, SPRIX® can cause fetal harm when administered to a pregnant woman due to an increased risk of premature closure of the ductus arteriosus. If SPRIX® is used at or after 30 weeks gestation, the patient should be apprised of the potential hazard to a fetus.

Hepatic Effects. Use SPRIX® with caution in patients with impaired hepatic function or a history of liver disease. Borderline elevations of one or more liver tests may occur in up to 15% of patients taking NSAIDs, including ketorolac. In addition, rare cases of severe hepatic reactions, including jaundice, fulminant hepatitis, liver necrosis, and hepatic failure, some of them with fatal outcomes, have been reported.

Inflammation and Fever. The pharmacological activity of SPRIX® in reducing inflammation and fever may diminish the utility of these diagnostic signs in detecting infections.

Preexisting Asthma. Patients with asthma may have aspirin-sensitive asthma. The use of aspirin in patients with aspirin-sensitive asthma has been associated with severe bronchospasm which can be fatal. Since cross reactivity, including bronchospasm, between aspirin and other NSAIDs has been reported in such aspirin-sensitive patients, do not administer SPRIX® to patients with this form of aspirin sensitivity, and use with caution in patients with preexisting asthma.

Eye Exposure. Avoid contact of SPRIX® with the eyes. If eye irritation occurs, wash out eye with water or saline, and consult a physician if irritation persists for more than one hour.

ADVERSE REACTIONS

The most frequently reported adverse reactions were related to local symptoms, i.e., nasal discomfort or irritation. These reactions were generally mild and transient in nature. The most common drug-related adverse events leading to premature discontinuation were nasal discomfort or nasal pain (rhinalgia).

The data described below reflect exposure to SPRIX® in patients enrolled in placebo-controlled efficacy studies of acute pain following major surgery. Most patients were receiving concomitant opioids, primarily PCA morphine.

Table 1. Post-operative Patients with Adverse Reactions Observed at a rate of 2% or more and at least twice the incidence of the placebo group.

	SPRIX® (N=455)	Placebo (N= 245)
Nasal discomfort	15%	2%
Rhinalgia	13%	<1%
Lacrimation increased	5%	0%
Throat irritation	4%	<1%
Oliguria	3%	1%
Rash	3%	<1%
Bradycardia	2%	<1%
Urine output decreased	2%	<1%
ALT and/or AST increased	2%	1%
Hypertension	2%	1%
Rhinitis	2%	<1%

In controlled clinical trials in major surgery, primarily knee and hip replacements and abdominal hysterectomies, seven patients (N=455, 1.5%) treated with SPRIX® experienced serious adverse events of bleeding (4 patients) or hematoma (3 patients) at the operative site versus one patient (N=245, 0.4%) treated with placebo (hematoma). Six of the seven patients treated with SPRIX® underwent a surgical procedure and/or blood transfusion and the placebo patient subsequently required a blood transfusion.

DRUG INTERACTIONS

Ketorolac is highly bound to human plasma protein (mean 99.2%). There is no evidence in animal or human studies that ketorolac induces or inhibits hepatic enzymes capable of metabolizing itself or other drugs.

Warfarin, Digoxin, Salicylate, and Heparin. Therapeutic concentrations of digoxin, warfarin, ibuprofen, naproxen, piroxicam, acetaminophen, phenytoin, and tolbutamide did not alter ketorolac protein binding.

Aspirin. When ketorolac is administered with aspirin, its protein binding is reduced, although the clearance of free ketorolac is not altered. The clinical significance of this interaction is not known; however, as with other NSAIDs, concomitant administration of SPRIX® and aspirin is not generally recommended because of the potential of increased side effects.

Diuretics. Clinical studies, as well as postmarketing observations, have shown that ketorolac can reduce the natriuretic effect of furosemide and thiazides in some patients.

Probenecid. Concomitant administration of oral ketorolac and probenecid resulted in decreased clearance and volume of distribution of ketorolac and significant increases in ketorolac plasma levels (total AUC increased approximately threefold from 5.4 to 17.8 mcg/h/mL), and terminal half-life increased approximately twofold from 6.6 to 15.1 hours. Therefore, concomitant use of SPRIX® and probenecid is contraindicated.

Lithium. NSAIDs have produced an elevation of plasma lithium levels and a reduction in renal lithium clearance. The mean minimum lithium concentration increased 15%, and the renal clearance was decreased by approximately 20%. Thus, when SPRIX® and lithium are administered concurrently, observe patients carefully for signs of lithium toxicity.

Methotrexate. NSAIDs have been reported to competitively inhibit methotrexate accumulation in rabbit kidney slices. This may indicate that they could enhance the toxicity of methotrexate. Use caution when SPRIX® is administered concomitantly with methotrexate.

ACE Inhibitors/Angiotensin II Receptor Antagonists. Concomitant use of ACE inhibitors and/or angiotensin II receptor antagonists may increase the risk of renal impairment, particularly in volume-depleted patients. Reports suggest that NSAIDs may diminish the antihypertensive effect of ACE inhibitors and/or angiotensin II receptor antagonists. Consider this interaction in patients taking SPRIX® concomitantly with ACE inhibitors and/or angiotensin II receptor antagonists.

Antiepileptic Drugs. Sporadic cases of seizures have been reported during concomitant use of ketorolac and antiepileptic drugs (phenytoin, carbamazepine).

Psychoactive Drugs. Hallucinations have been reported when ketorolac was used in patients taking psychoactive drugs (fluoxetine, thiothixene, alprazolam).

Pentoxifylline. When ketorolac is administered concurrently with pentoxifylline, there is an increased tendency to bleeding. Therefore, concomitant use of SPRIX® and Pentoxifylline is contraindicated.

Nondepolarizing Muscle Relaxants. In postmarketing experience there have been reports of a possible interaction between ketorolac and nondepolarizing muscle relaxants that resulted in apnea.

Selective Serotonin Reuptake Inhibitors (SSRIs). There is an increased risk of gastrointestinal bleeding when selective serotonin reuptake inhibitors (SSRIs) are combined with NSAIDs.

Fluticasone/Oxymetazoline. The rate and extent of absorption of ketorolac from SPRIX® administration were assessed in subjects with allergic rhinitis before and after the administration of a single daily dose of fluticasone and oxymetazoline. There was no effect on the pharmacokinetic characteristics of SPRIX® that can be considered clinically significant.

DRUG ABUSE AND DEPENDENCE

Ketorolac does not bind to opiate receptors.

Symptoms and Signs. Symptoms following acute NSAID overdose are usually limited to lethargy, drowsiness, nausea, vomiting, and epigastric pain, which are generally reversible with supportive care. Gastrointestinal bleeding can occur. Hypertension, acute renal failure, respiratory depression, and coma may occur, but are rare.

Treatment. Manage patients using symptomatic and supportive care following an NSAID overdose. There are no specific antidotes.

PATIENT COUNSELING INFORMATION

Instruct patients to read the NSAID Medication Guide that accompanies each prescription dispensed.

may push participants toward an agreement. In general, except in those few cases that are only about money, a mediator who takes a facilitative rather than an evaluative approach and is comfortable with expression of strong feelings is more likely to help participants achieve the full range of benefits offered by the process.

Communication That Helps to Heal

The type of communication encouraged in mediation is quite different from the healthcare system's traditional "deny-and-defend" mindset designed to enhance chances of winning should a lawsuit become one of the 5%-6% of cases that actually goes to trial. Until recently, physicians were advised to say as little as possible after an error and certainly not to apologize. This approach has begun to shift to disclosure and, when appropriate, apology and offer of fair compensation, thanks to the leadership of institutions like the University of Michigan Health System, the Lexington, Kentucky Veterans Administration Hospital, and the Colorado liability insurer COPIC, as well as to research documenting what patients seek after an adverse event.

This research has found that among the key outcomes patients seek are information about what went wrong, an apology, money to compensate for their injuries, and changes in clinic or hospital practice to better ensure that others do not suffer from similar harm. Patients often sue because they cannot get answers to their questions and suspect a cover-up because of evasive communication.

The negative reactions of patients and their families to inadequate communication that results from institutional deny-and-defend policies is no doubt heightened by the impact of an error on members of the medical team. In addition to fear of litigation and advice from their lawyers to be cautious about what they say, physicians and other members of the team must deal with the very normal human reactions of shame, guilt, and failure—feelings that make it hard to communicate at just the time that patients and family members are most in need of both emotional support and information.

Physician Participation Is Needed

Ideally medical practices and hospitals will have policies in place so that when things go wrong, patients receive initial expressions of empathy such as "I'm sorry this happened to you" and information about what is known at that point. Patients should also be told what will be done to investigate an adverse event and gather

more information. And they should be kept apprised of the investigation's findings. If the investigation reveals that an error did occur, the policy would provide for an offer of fair compensation, and, when fault is clear, an apology that takes responsibility for the harm: "I'm sorry for my/our error." In addition, patients and family members would be told what is being done to prevent the error from happening again.

Even with such a policy, there will be lawsuits. And, when patients sue, mediation provides another opportunity to communicate, repair relationships, avoid economic and emotional cost, and learn from regrettable events. But most benefits of mediation are lost if one of the key players in the case, the physician, chooses not to attend or is advised not to by a trial lawyer who is professionally acculturated to prefer combat in court.

When we asked defense lawyers in our study why—despite being urged to bring their clients to the mediation during pre-mediation conference calls—physicians did not attend, we were told that the physicians were too busy or that the lawyers wanted to protect them from verbal attack by the plaintiffs. While both are understandable concerns, they reflect a narrow vision of the goals of mediation and, in most instances, ensure that the "treatment" offered by mediation will not be effective.

When physicians stay away from the mediation table, everyone loses. The physicians, the patients, and their families lose the opportunity to reconcile. The physician loses the opportunity to be forgiven and the patient or family the opportunity to forgive. The physician, hospital, patient, and patient's family all lose the chance for information giving and gathering and the opportunity to consider changes in institutional policies and practices to enhance both the quality of medical care and the delivery of caring services.

What is needed are physicians who partner with their lawyers to take full advantage of the mediation process by participating in the sessions. Failure to attend disappoints the plaintiffs and can be interpreted as a signal that, even after serious harm, the physician does not care enough to show respect by attending, listening, and providing information.

There will always be places for physicians at the mediation table. Even when attending is difficult, it is time for physicians to pull up their chairs. ■

Reference

1. Hymen CS, Liebman CB, Schechter CB, Sage WM. Interest-based mediation of medical malpractice lawsuits: a route to improved patient safety? *Journal of Health Politics, Policy and Law*. 2010;35(5):797-828. Available at: <http://jhppl.dukejournals.org/content/35/5/797.abstract>. Accessed September 10, 2011.



Aequanimitas*

■ JOHN SHUFELDT, MD, JD, MBA, FACEP

"Thou must be like a promontory of the sea, against which, though the waves beat continually, yet it both itself stands, and about it are those swelling waves stilled and quieted."

—Marcus Aurelius

It is important to reflect occasionally on where one's path began inasmuch as we owe a debt to those who have advanced our current purpose, whether family, business, or profession. The goal of this reflection should hopefully include an appreciation of the sacrifices of those who blazed the trail ahead of us as well as a critical appraisal of current efforts to ensure mistakes of the past are not repeated.

William Osler, considered to be one of the fathers of modern medicine, (Halstead, Kelly, and Welch were the other renowned faculty members at Johns Hopkins in the late 19th Century) was known for actually bringing medical students to the patients on rounds and for starting the first formal residency program. To give you some historical perspective, during the late 1800's, Halstead was just starting to use cocaine (personally as well as on his patients) as an anesthetic; aseptic technique in the operating room was being practiced only at Hopkins; and wealthy patients had surgery in their own homes.

It was during this era (1889) that Osler gave a farewell valedictory address titled *Aequanimitas* to the medical students at the University of Pennsylvania when he left to become the first physician-in-chief at the Johns Hopkins Medical School.

The address focused on two related words, *aequanimitas* and *imperturbability*, which, according to Osler, may be the two most important traits a physician can possess:

In the first place, in the physician or surgeon no quality takes rank with imperturbability, and I propose for a few

minutes to direct your attention to this essential bodily virtue. Perhaps I may be able to give those of you, in whom it has not developed during the critical scenes of the past month, a hint or two of its importance, possibly a suggestion for its attainment. Imperturbability means coolness and presence of mind under all circumstances, calmness amid storm, clearness of judgment in moments of grave peril, immobility, impassiveness ...

The virtue of *aequanimitas* (which Osler considered the mental equivalent of imperturbability) not only is vital in the practice of medicine but also serves us well in other pursuits, particularly as they relate to the development and operation of urgent care centers. As with all important endeavors, the clause "if it were easy, everyone would do it" is true for practicing medicine and opening and operating urgent care centers.

The challenges experienced surrounding the day-to-day operations of centers can certainly cause an owner/operator to be much less than calm by the end of the day. The vagrancies of patient flow and resultant revenue fluctuations; the idiosyncrasies, diverse backgrounds, and education of the staff; and the challenges of payer reimbursement make operating urgent care centers ill-advised for the weak-willed.

Over the years spent in the ED and managing urgent care centers, I have witnessed the occasional provider and more than a few urgent care operators become unhinged during real or imagined crises. Nothing does more to raise the anxiety of patients or employees than to see the person whose expertise upon which they are reliant "lose it." Despite its clear necessity, I am uncertain if calmness under pressure comes from genes or training. Osler had this to say:

As imperturbability is largely a bodily endowment, I regret to say that there are those amongst you, who, owing to congenital defects, may never be able to acquire it. Education, however, will do much; and with practice and experience the majority of you may expect to attain to a fair measure. The first essential is to have your nerves well in hand. Even under the most serious circumstances, the physician or surgeon who allows "his out-

*Aequanimitas = equanimity (Latin).



John Shufeldt is principal of Shufeldt Consulting and sits on the Editorial Board of JUCM. He may be contacted at JohnShufeldt@shufeldtconsulting.com.

ward action to demonstrate the native act and figure of his heart in complement extern," who shows in his face the slightest alteration, expressive of anxiety or fear, has not his medullary centres under the highest control, and is liable to disaster at any moment.

How then does one become the face of serenity during the storm? Clearly, training and experience count for much; I can remember my hand trembling the first time I sutured a patient or delivered a baby. I like to think that after the first few seconds I regained my steadiness that the patient's laceration eventually healed and the child was born without shaken baby syndrome.

In a true and perfect form, imperturbability is indissolubly associated with wide experience and an intimate knowledge of the varied aspects of disease. With such advantages he is so equipped that no eventuality can disturb the mental equilibrium of the physician; the possibilities are always manifest, and the course of action clear. Keen sensibility is doubtless a virtue of high order, when it does not interfere with steadiness of hand or coolness of nerve; but for the practitioner in his working-day world, a callousness which thinks only of the good to be effected, and goes ahead regardless of smaller considerations, is the preferable quality.

A friend of mine once said that the key to happiness is a short memory and low expectations. Over the years, and particularly over this last year, this admonition saved a couple of non-notables from an untimely demise. For whatever reasons, there are a few hapless individuals, patients and otherwise, I have met along the way, who, despite their remarkable lack of the basics of human niceties and professional behavior, deserve pity as opposed to scorn.

How difficult to attain, yet how necessary, in success as in failure! Natural temperament has much to do with its development, but a clear knowledge of our relation to our fellow-creatures and to the work of life is also indispensable. One of the first essentials in securing a good-natured equanimity is not to expect too much of the people amongst whom you dwell. "Knowledge comes, but wisdom lingers," and in matters medical the ordinary citizen of today has not one whit more sense than the old Romans ...

For anyone who has started a venture that ultimately failed or for those who struggled but were eventually successful, take some comfort in that, at the end of the day, you are better for the effort, whether it was a success or a failure.

It is sad to think that, for some of you, there is in store disappointment, perhaps failure. You cannot hope, of course, to escape from the cares and anxieties incident to professional life. Stand up bravely, even against the worst. Remember, too, that sometimes "from our desolation only does the better life begin." Even with disaster ahead and ruin imminent, it is better to face them with a smile, and with the head erect, than to crouch at their approach. It has been said that "in patience ye shall win your souls," and what is this patience but an equanimity which enables you to rise superior to the trials of life.

I find it fascinating that 112 years after Osler sent off the medical students with *aequanimitas*, as a profession we still occasionally have to be reminded that despite some of the challenges with Osler's stilted diction, his remarks still hold true: for urgent care physicians and owners, imperturbability and *aequanimitas*, whether acquired or developed, are incredibly beneficial traits that will make the transit through this life much more enjoyable.

Or, if Osler is a bit prosaic, as Judge Elihu Smails said in *Caddyshack*: "It easy to grin when your ship comes in and you've got the stock market beat. But the man worthwhile, is the man who can smile, when his shorts are too tight in the seat." ■

Had Any Interesting Cases Lately?

Case Reports are one of *JUCM*'s most popular features. Case Reports are short, didactic case studies of 1,000-1,500 words. They are easy to write and *JUCM* readers love them. If you've had some interesting cases lately, please write one up for us. Send it to Neil Chesanow, *JUCM*'s editor, at nchesanow@jucm.com.

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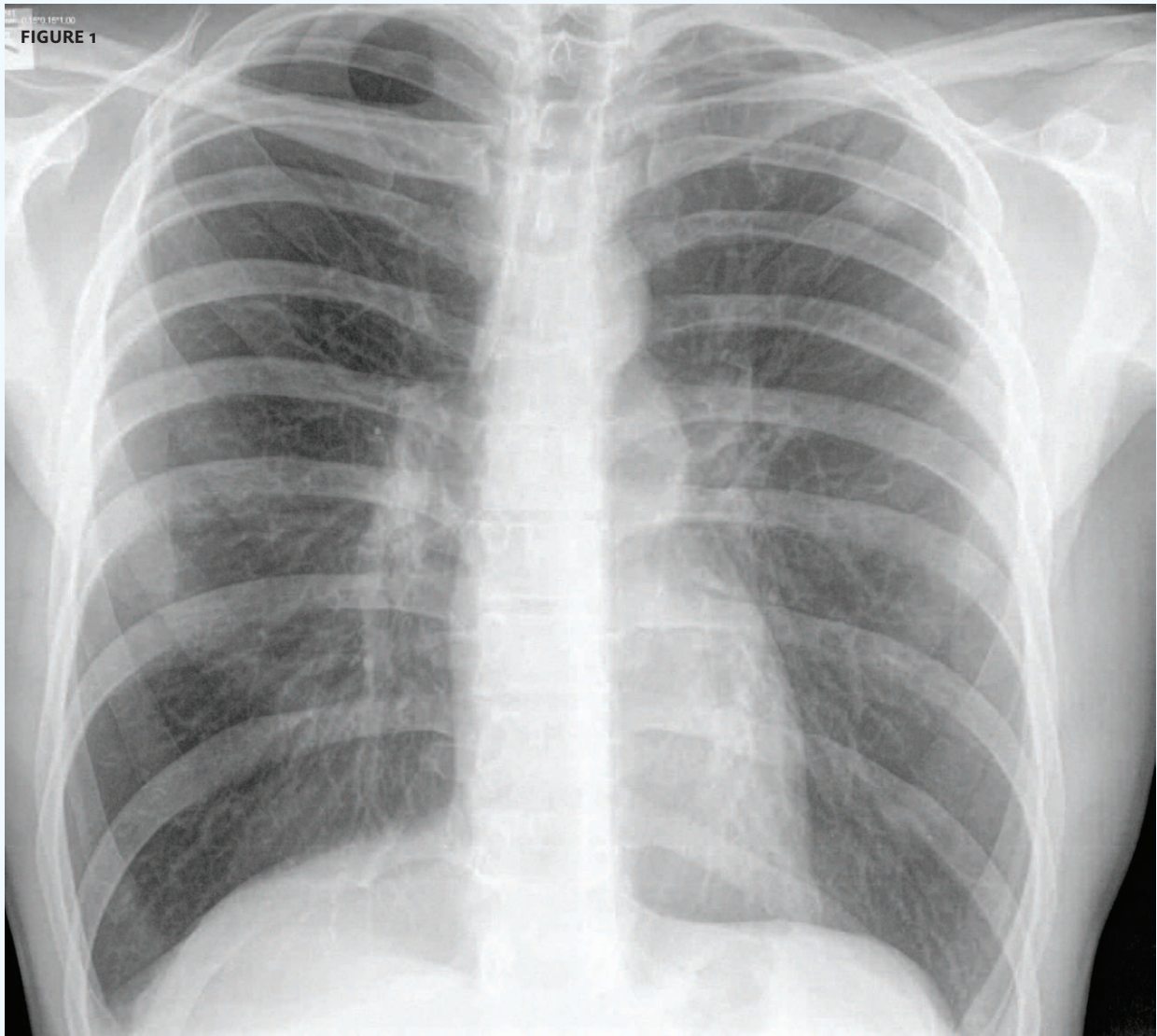


INSIGHTS IN IMAGE

CLINICAL CHALLENGE: CASE 1

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

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

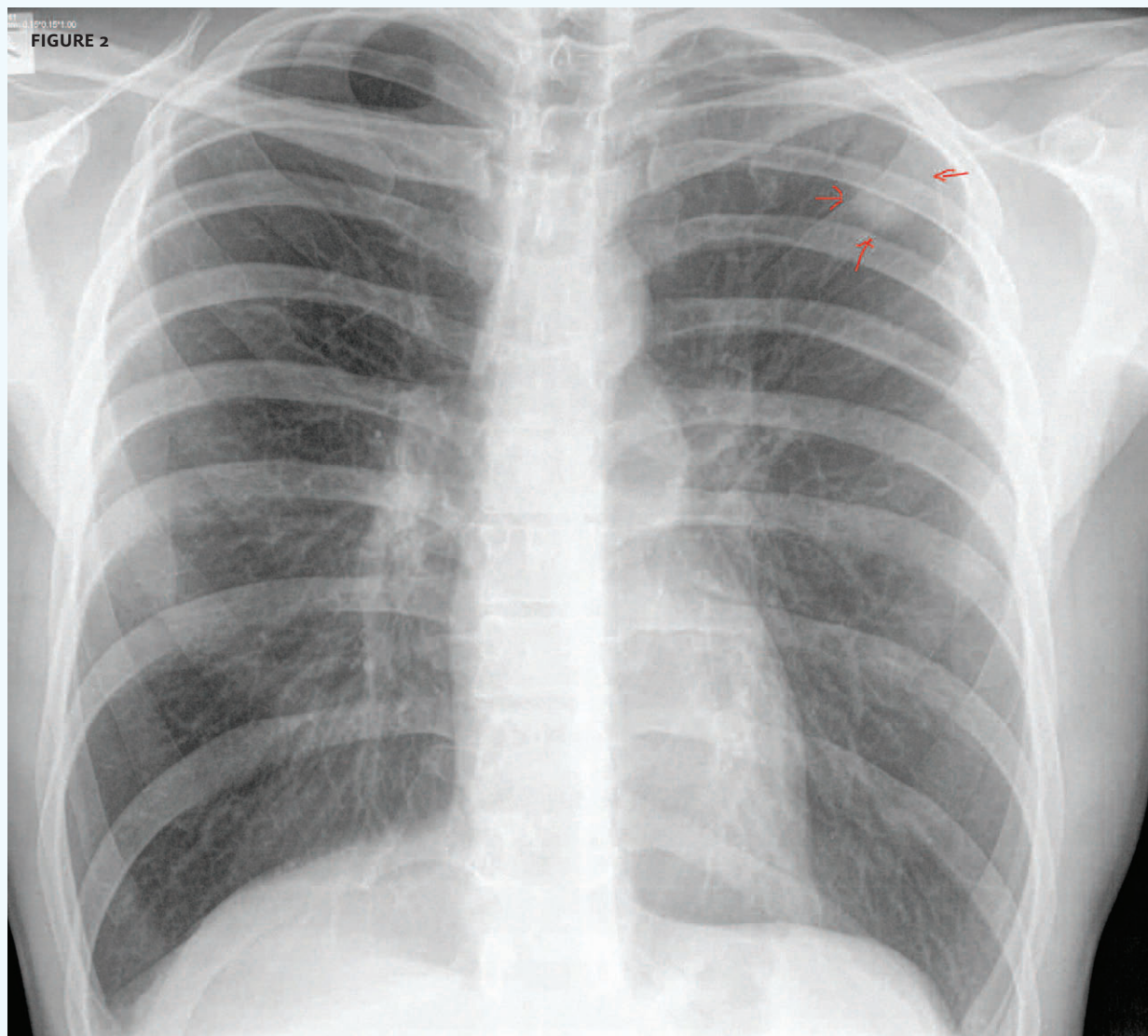


The patient, an otherwise healthy 45-year-old, has had a cough for a month. Location: left side of the chest.

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

Resolution of the case is described on the next page.

THE RESOLUTION



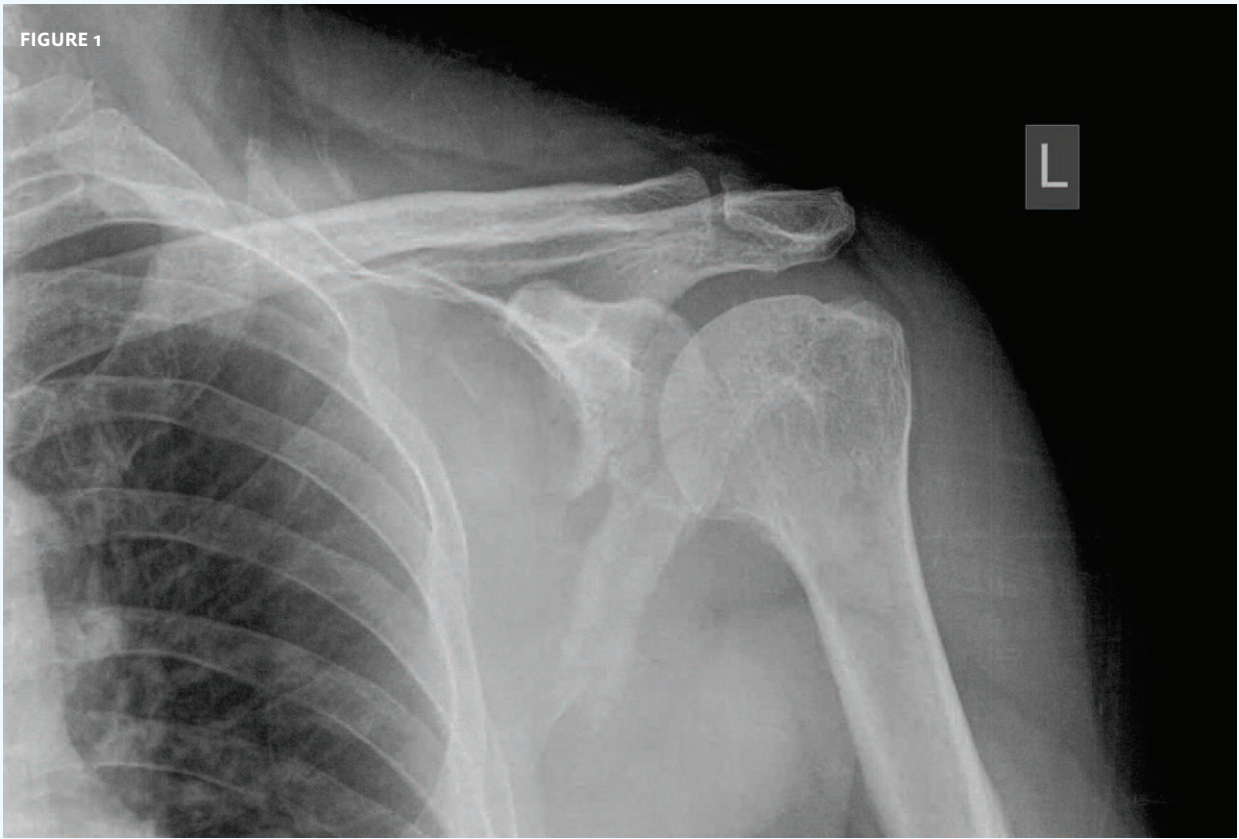
There is a round lesion in the lung that requires follow-up, most likely CT.

Solitary round lesions of less than 3 cm are often benign tumors like granulomas or hamartomas. However, 20% of these are malignant, so additional follow-up and imaging are necessary.

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



FIGURE 1



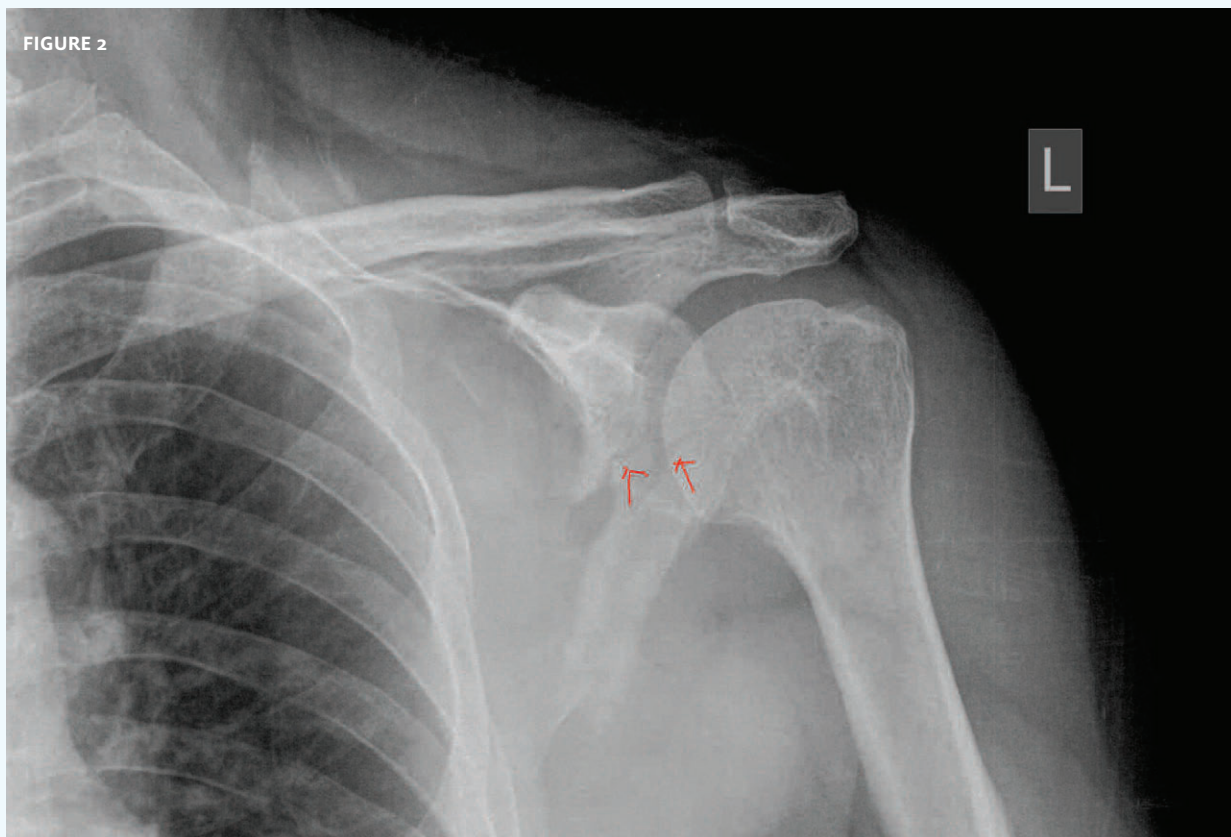
The patient, an otherwise healthy 71-year-old, suffered a blow to the left shoulder.

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

Resolution of the case is described on the next page.

THE RESOLUTION

FIGURE 2

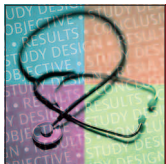


The diagnosis is fracture of the scapula.

Next steps: rest, sling, and follow up with an orthopedist.

Scapular fractures are associated with other severe injuries and the patient must be fully evaluated.

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



ABSTRACTS IN URGENT CARE

- Effectiveness of Chinese Herbs for Influenza
- Cranberries vs TMP-SMX for Urinary Tract Infections
- Holter Monitoring, Octogenarians, and Syncope
- New Guidelines for Febrile UTI in Infants and Young Children
- New Guidelines for Pediatric CAP
- Influenza Vaccination in the US (2011-2012)
- FDA Warning Re: Zofran; Abnormal Heart Rhythms
- Pertussis Vaccine Protection Wanes in ≥ 3 Years
- Lab Testing in Chronic Urticaria Not Helpful
- Low Back Pain: Patient-tailored Treatment Is Best

■ NAHUM KOVALSKI, BSc, MDCM

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

Chinese Herbs Are as Efficient as Oseltamivir for Shortening Flu Symptoms

Key point: Traditional Chinese herbal therapy resolves fever in influenza as quickly as oseltamivir.

Citation: Wang C, Cao B, Liu Q-Q, et al. Oseltamivir compared with the Chinese traditional therapy maxingshigan-yinqiaosan in the treatment of H1N1 influenza: a randomized trial. *Ann Int Med.* 2011;155(4):217-225.

Researchers studied some 400 adults and adolescents in 11 Chinese hospitals who had uncomplicated 2009 H1N1 influenza A. Patients, who remained in the hospital for quarantine purposes and not the severity of their illness, were randomized to one of four groups: maxingshigan-yinqiaosan, oseltamivir, maxingshigan-yinqiaosan plus oseltamivir, or no treatment. (Maxingshigan-yinqiaosan comprises 12 herbs, including ephedra, which is restricted in the US)

The median time to fever resolution was significantly shorter with oseltamivir (20 hours), maxingshigan-yinqiaosan (16),

and combination therapy (15) than with no treatment (26). Symptomatic improvement did not differ among the treatment groups. Two patients using maxingshigan-yinqiaosan had nausea and vomiting.

The authors conclude that the herbal treatment can be used as an alternative when oseltamivir is not available. ■

Cranberries vs TMP-SMX to Prevent Urinary Tract Infections

Key point: Trimethoprim-sulfamethoxazole was better at preventing UTIs, at the expense of greater antibiotic resistance.

Citations: Beerepoot MA ter Riet G, Nys S, et al. Cranberries vs antibiotics to prevent urinary tract infections: a randomized double-blind noninferiority trial in premenopausal women. *Arch Intern Med.* 2011;171(14):1270-1278.

Gurley BJ. Cranberries as antibiotics? *Arch Intern Med* 2011; 171(14):1279-1280.

Premenopausal women who experience recurrent urinary tract infections (UTIs) are sometimes prescribed low-dose antibiotic prophylaxis. Growing concern about antibiotic resistance, coupled with many patients' desire for non-pharmacologic remedies, has led to renewed interest in cranberry consumption for UTI prophylaxis. The presumed mechanism is prevention of bacterial adhesion to uroepithelial cells by proanthocyanidins, a con-



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

stituent of cranberries.

In a double-blind study, Dutch investigators randomized 221 women (median age, 35) who reported having a median of 6-7 UTIs in the previous year to receive either cranberry extract (500 mg twice daily) or trimethoprim-sulfamethoxazole (TMP-SMX; 480 mg nightly). During 12 months of treatment, cranberry-extract recipients had a mean of 4 symptomatic UTIs compared with a mean of 1.8 in the TMP-SMX group—a significant difference; the median time to first recurrence was 4 months in the cranberry group and 8 months in the antibiotic group. Adverse events did not differ between groups, but the dropout rate was about 50% in both.

Published in *J Watch Gen Med*. August 4, 2011—Thomas L. Schwenk, MD. ■

Holter Monitoring in Octogenarians with Syncope

Key point: 11% of patients had symptomatic arrhythmias.

Citation: Kuhne M, Schaer B, Sticherling C, Osswald S. Holter monitoring in syncope: diagnostic yield in octogenarians. *J Am Geriatr Soc*. 2011;59(7):1293-1298.

The yield of Holter monitoring in patients with syncope depends on clinical characteristics and patient age, which affect pretest probability of an arrhythmic cause. In this study, Swiss researchers examined the diagnostic yield of 24-hour Holter monitoring in 475 consecutive patients (age, >80; 13% ≥90) with syncope. Patients whose initial evaluations revealed obvious causes of syncope (eg, orthostatic hypotension, diagnostic 12-lead electrocardiogram [ECG] finding) and those with previously implanted pacemakers were excluded. At baseline, half the patients had known structural heart disease.

Holter monitoring was diagnostic (ie, detected an arrhythmic abnormality associated with symptoms) in 11% of patients. Most diagnostic abnormalities were bradyarrhythmias (eg, sinus node dysfunction, atrioventricular block, atrial fibrillation with slow response) and resulted in appropriate pacemaker implantation. In addition, 10% of patients had symptoms while monitoring was normal, presumably ruling out an arrhythmic cause of syncope.

Published in *J Watch Gen Med*. August 11, 2011—Allan S. Brett, MD. ■

New AAP Guidelines for Diagnosis and Management of Febrile UTI in Infants and Young Children

Key point: These recommendations outline a systematic approach to diagnosis and management that minimizes harm, maximizes benefit, and optimizes use of labs and procedures.

Citation: Subcommittee on Urinary Tract Infection. Urinary tract infection: clinical practice guideline for the diagnosis and management of the initial UTI in febrile infants and children

2 to 24 months. *Pediatrics*. [Epub ahead of print.]

Diagnosis and management of urinary tract infection (UTI) in febrile infants are challenging for several reasons: Obtaining a sterile urine sample requires either inserting a urethral catheter or performing a suprapubic aspirate, both the route and duration of antibiotics are not standardized, and follow-up evaluation often includes voiding cystourethrography (VCUG) that involves irradiation of the pelvis. The American Academy of Pediatrics Subcommittee on UTI extensively reviewed studies published during the past 10 years on UTI in young children and developed sensible, updated, evidence-based guidelines to direct practitioners in the diagnosis and management of febrile UTI in children aged 2 to 24 months. The seven key action statements are as follows:

Diagnosis

1. If a febrile patient with no known source of fever is deemed ill enough to require immediate antibiotic therapy, obtain urine culture by either catheterization or suprapubic aspiration before initiating treatment.
2. Assess the likelihood of UTI. Risk factors for UTI are female sex, not being circumcised, no other source of fever, and fever ≥39°C. Additional risk factors in girls are white race, age <12 months, and fever for >2 days. Additional risk factors in boys are nonblack race and fever for ≥24 hours.
 - Low-risk patients can be followed clinically without urine evaluation.
 - In patients who are not low risk, obtain a urine culture by either catheterization or suprapubic aspiration for urinalysis and culture, or obtain a urine specimen for urinalysis followed by culture if positive.
3. Establish UTI diagnosis. Diagnosis requires both abnormal urinalysis (pyuria, bacteriuria, or both) and urine culture with >50,000 CFU/mL of a urinary pathogen.

Management

4. Oral therapy and parenteral therapy are both efficacious, and decisions should be based on practical considerations (eg, the patient's ability to take oral medication). Adjust antibiotics according to sensitivity patterns. Minimal duration of therapy is 7 days. No differences in efficacy have been documented among 7-, 10-, and 14-day regimens.
5. Evaluation after a first febrile UTI should include renal and bladder ultrasound. Increasing evidence indicates that antibiotic prophylaxis for low-grade reflux does not improve outcomes. Therefore, routine VCUG is not recommended after a first UTI.
6. VCUG should be performed in patients with a first UTI *only* if ultrasound suggests high-grade vesicoureteral reflux. VCUG is indicated for recurrent febrile UTI.

Certified Urgent Care Centers

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

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DoctorsCare Sango Clinic

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Immediate Care Center: the Doctor is IN

Freedom Urgent Care

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North Country Urgent Care

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Atlantis Urgent Care

ExpressMD Urgent Care

Doctors Care Easley

Doctors Care Irmo

MediQuick Urgent Care Centers, Pinnacles Drive

MediQuick Urgent Care Centers, Office Park Drive

MediQuick Urgent Care Centers

Urgent Care of Norwalk

OhioHealth Urgent Care - Dublin

OhioHealth Urgent Care - Victorian Village

OhioHealth Urgent Care - New Albany

OhioHealth Urgent Care - Lewis Center

OhioHealth Urgent Care - Grove City

Kootenai Urgent Care, West Prairie Avenue

Kootenai Urgent Care, Ironwood Drive

Kootenai Urgent Care

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Palm Coast, FL

Green Cove Springs, FL

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Columbus, OH

Columbus, OH

Powell, OH

Grove City, OH

Coeur d'Alene, ID

Coeur d'Alene, ID

Post Falls, ID

Mobile, AL

Cheyenne, WY

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



7. Following a confirmation of UTI, physicians should instruct parents to seek prompt care for future unexplained febrile illness.

Published in *J Watch Pediatr and Adolesc Med*. September 21, 2011—Peggy Sue Weintrub, MD. ■

Infectious Diseases Groups Issue First Guidelines on Managing Pediatric CAP

Key point: *The guidelines comprise 92 specific recommendations on prevention, testing, and treatment.*

Citation: Bradley JS, Byington CK, Shah SS, et al. The management of community-acquired pneumonia in infants and children older than 3 months of age: clinical practice guidelines by the Pediatric Infectious Diseases Society and the Infectious Diseases Society of America. *Clin Infect Dis*. 2011. Available at: <http://cid.oxfordjournals.org/content/early/2011/08/30/cid.cir531.full>.

The Pediatric Infectious Diseases Society and the Infectious Diseases Society of America have published a comprehensive guideline for the diagnosis, treatment, and management of community-acquired pneumonia (CAP) in otherwise healthy infants and children older than 3 months. The evidenced-based guideline includes detailed recommendations for every aspect of care and explanations for each recommendation. Some notable features are as follows:

Hospitalization

Children who are likely to require hospitalization include those with oxygen saturation <90% or community-acquired methicillin-resistant *Staphylococcus aureus* (MRSA), those who are unable to be followed or to comply with therapy, and those between ages 3 and 6 months.

Testing for respiratory viruses

Children with CAP should be tested for respiratory viruses, particularly influenza. A positive result can decrease antibiotic use and hasten treatment of influenza.

Diagnostic tests in outpatients

Children who are well enough to be managed as outpatients do not require chest x-rays or complete blood cell count; fully immunized children do not require blood cultures.

Treatment in outpatients

Many preschool-age children have viral disease and can be supported without antibiotics. When bacterial disease is suspected, amoxicillin remains the mainstay of therapy. A macrolide can be added when infection caused by an atypical pathogen is suspected.

Treatment in hospitalized patients

Treatment options can range from amoxicillin or penicillin to vancomycin (or clindamycin) and ceftriaxone depending on such factors as suspicion for various pathogens, knowledge of local susceptibility patterns, and concern for MRSA.

Duration of antibiotic therapy

Duration can range from 7 to 10 days for outpatients and patients who respond well to antibiotics. Duration is longer (often 2 to 4 weeks) for patients with MRSA or complicated CAP. Change from intravenous to oral medications when patients can tolerate them.

Management of complicated CAP

The guideline offers suggestions for managing CAP with effusions, loculations, and abscess formation. Surgical consultation is useful for making management decisions in complicated cases.

Follow-up chest x-rays

Routine follow-up x-rays are *not* indicated for children with clinical resolution without complications.

Published in *J Watch Pediatr and Adolesc Med*. September 28, 2011—Peggy Sue Weintrub, MD. ■

Influenza Vaccination in the US, 2011–2012

Key point: *The CDC recently released its recommendations for use of this year's vaccine.*

Citation: Centers for Disease Control and Prevention (CDC). Prevention and control of influenza with vaccines: recommendations of the Advisory Committee on Immunization Practices (ACIP), 2011. *MMWR Morb Mortal Wkly Rep*. 2011;60(33):1128–1132.

On August 18, the CDC released guidance for use of influenza vaccines for the 2011–2012 influenza season, based on recommendations from the Advisory Committee on Immunization Practices. Vaccination of all individuals in the US aged ≥6 months continues to be recommended. The vaccine virus strains are the same as those for the 2010–2011 season. Nonetheless, for optimal protection against influenza, annual immunization is recommended—even for persons who received the vaccine last year. ■

FDA warns of abnormal heart rhythms with Zofran

Key point: *Important warning.*

Citation: US Food and Drug Administration (FDA). Zofran (ondansetron): Drug Safety Communication—Risk of Abnormal Heart Rhythms. FDA website. Available at: <http://www.fda.gov/Safety/MedWatch/SafetyInformation/Safety>

AlertsforHumanMedicalProducts/ucm272041.htm. Accessed October 7, 2011.

The anti-nausea drug ondansetron (marketed as Zofran and in generic forms) should not be used in patients with congenital long QT syndrome, as they are at particular risk for developing torsade de pointes while taking the drug.

Also at increased risk are patients with congestive heart failure or bradyarrhythmias, those predisposed to low potassium and magnesium levels, and those taking other drugs that can lead to QT prolongation. Accordingly, ECG monitoring is now recommended for such patients using ondansetron.

The drug's label is being revised to include this new information. (The label had previously noted the potential for QT prolongation.) The FDA asks clinicians to report incidents to its Adverse Event Reporting Program. ■

Vaccine Protection Against Pertussis May Wane Sooner Than Thought

Key point: *There was a recently widely reported study suggesting that the pertussis vaccine loses its effectiveness as early as 3 years after the last shot of the five-dose series*

Citation: Study: Whooping cough vaccination fades in 3 years. Boston.com. Available at: http://articles.boston.com/2011-09-19/lifestyle/30176444_1_whooping-cough-booster-shot-highly-contagious-bacterial-disease. Accessed October 7, 2011.

A study, presented at the American Society for Microbiology conference in Chicago, studied some 15,000 children in California, including 132 who developed pertussis in 2010. They found that the risk for pertussis was up to 20-fold higher in children who'd received their last dose of vaccine at least 3 years previously compared with those who'd been vaccinated more recently. Children aged 8 to 12 years were at greatest risk. (The last of the 5 shots is usually given between ages 4 and 6, with a booster dose around age 11 or 12).

More than four-fifths of infected children had been vaccinated fully.

CDC officials acknowledged that the vaccine's protection declines, but they said the agency's own studies show the drop-off is not as pronounced as that observed here. ■

Lab Testing Isn't Helpful in Patients with Chronic Urticaria

Key point: *Among 350 patients, 17% of test results were outside the normal range, but only 1.6% led to further evaluation, and only one patient benefited*

Tarbox JA, Gutta RC, Radojicic C, Lang DM. Utility of routine laboratory testing in management of chronic

urticaria/angioedema. *Ann Allergy Asthma Immunol.* 2011;107(3):239-243.

Even with extensive testing, a cause for chronic urticaria (CU) rarely is established. Although not evidence-based, US practice parameters from 2000 recommend complete blood count (CBC), urinalysis, liver function tests, erythrocyte sedimentation rate (ESR), and thyroid-stimulating hormone (TSH) measurement (*Ann Allergy Asthma Immunol* 2000;85:521). European guidelines recommend only CBC and ESR (*Br J Dermatol* 2001;144:708). Cleveland Clinic researchers conducted a retrospective review of 356 patients (69% women) with CU at their allergy clinic.

Patients underwent a median of six tests (total, 1872), and 17% of studies were abnormal. The most commonly ordered tests were TSH (performed in 74% of patients), CBC (73%), comprehensive or basic metabolic panels (71%), ESR (60%), anti-thyroid antibodies (50%), urinalysis (39%), and antinuclear antibodies (37%); 1.6% of abnormal tests results led to further work-ups, including specialist consultation or additional laboratory testing. Only one patient seemed to benefit from such testing: Her thyroxine dose was increased based on a high TSH result, and her urticaria resolved.

Published in J Watch Gen Med. September 29, 2011—David J. Amrol, MD. ■

Low Back Pain: Tailoring Patients' Treatment Improves Outcomes, Saves Money

Key point: *When it comes to managing back pain, assessing patients' risk for persistent disability and tailoring treatment according to that risk improves symptoms and lowers costs*

Citation: Hill JC, Whitehurst DGT, Lewis M, et al. Comparison of stratified primary care management for low back pain with current best practice (STarT Back): a randomised controlled trial. *Lancet*. [Epub ahead of print.]

Some 850 UK adults with low back pain completed a 9-item screening questionnaire and then were classified as being at low, medium, or high risk for ongoing disability. In the intervention group, care was tailored to patients' level of risk: low-risk patients had only a baseline clinic visit, medium-risk patients were referred for physiotherapy, and high-risk patients were referred for physiotherapy plus counseling to overcome psychosocial barriers to recovery. In the control group, clinicians were blinded to patients' risk classification and made referrals according to their own judgment.

At 12 months, both disability scores and costs were lower in the intervention group than in the control group.

A commentator calls the results "very promising" but acknowledges that there will be challenges to implementing the approach. ■



Nebulizer Supplies, Diltiazem IV, Influenza Vaccines with E/M Codes, and Critical Care Coding in Urgent Care

■ DAVID STERN, MD, CPC

Q. I am using an EHR, but it does not seem to code nebulizer treatments correctly. It produces codes 94640 (nebulizer treatment) and J7620 (albuterol/ipratropium bromide), but it misses the codes for administration set, with small volume non-filtered pneumatic nebulizer, disposable (A7003) and tubing (A7011). Why is this?

A. The administration set code (A7003) and tubing code (A7011) code are actually bundled into the code for the treatment (ie, they are included in 94640). Thus, it is not appropriate to add these codes when your clinic performs nebulizer treatments.

Q. What HCPCS code should my clinic use for diltiazem IV?

A. Unfortunately, there is no HCPCS code for IV diltiazem. You will have to eat the cost.

Q. Our doctor personally checks each pediatric patient before giving the influenza vaccine, so we would like to know if we can add an E/M code to the visit and if a copay can be collected?

A. As far as adding an E/M code to a visit for a vaccination, this would depend on the visit. For most routine patient visits that are just to administer an influenza vaccination, a separate E/M would not be medically necessary.



David E. Stern is a certified professional coder. He is a partner in Physicians Immediate Care, operating 18 clinics in Illinois, Oklahoma, and Nebraska. Dr. Stern was a Director on the founding Board of UCAOA and has received the Lifetime Membership Award of UCAOA. He serves as CEO of Practice Velocity (www.practicevelocity.com), providing software solutions to over 750 urgent care centers in 48 states. He welcomes your questions about urgent care in general and about coding issues in particular.

“For most routine patient visits that are just to administer an influenza vaccination, a separate E/M would not be medically necessary.”

If there is medical necessity for additional evaluation and management and the physician documents the history, physical, assessment, and plan, then it would be appropriate to document the additional information and code the E/M based on the evaluation and management. Thus, for a patient presenting for a DTaP, who had suffered a significant reaction to a previous DTaP or was suffering a concurrent respiratory infection, then it might be appropriate for the physician to perform a direct evaluation and management of the patient.

If the physician provides counseling related to the vaccination, the procedure should be coded with 90460—*Immunization administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional; first vaccine/toxoid component*. Since the code specifically includes counseling related to the vaccination, you should not add an E/M for just adding counseling to the visit for a child through 18 years of age.

If the patient receives an annual wellness exam during the same visit, it would be appropriate to choose the proper

CODING Q & A

code (99391-99397) based on the age of the patient (eg, 99393, *Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; late childhood [age 5 through 11 years]*).

Q. How would you code an urgent care visit for chest pain with hypertension for nitroglycerine monitoring with serial VS monitoring, ECGs, and stabilization of the patient?

A. You would usually code either:

- E/M (99205 or 99215: *new patient, physician office visit*). Make sure that you provide proper documentation to support this code.
- Critical care (99291—*Critical care, evaluation and management of the critically ill or critically injured patient, first 30-74 minutes*). You may use this higher-paying code outside of a hospital in an urgent care, but you must follow CPT guidelines for reporting critical care services. The two key points of the CPT definition of critical care are:
 - The patient must be suffering a critical illness or injury as defined by CPT: an illness or injury that “acutely impairs one or more vital organ systems such that there is a high probability of imminent or life-threatening deterioration in the patient’s condition.”
 - In critical care, the physician treats single or multiple vital organ system failure(s) and/or prevents further life-threatening deterioration of the patient’s condition, and the physician must continue these life-sustaining services for at least 30 minutes.

Although the physician does not usually provide these services in an urgent care center for an extended time, the physician may perform them until the patient can be transported to a hospital. In general, critical care codes are easier to document than other E/M services, as you must simply note the reason for the critical care, the time spent, the specific care given.

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

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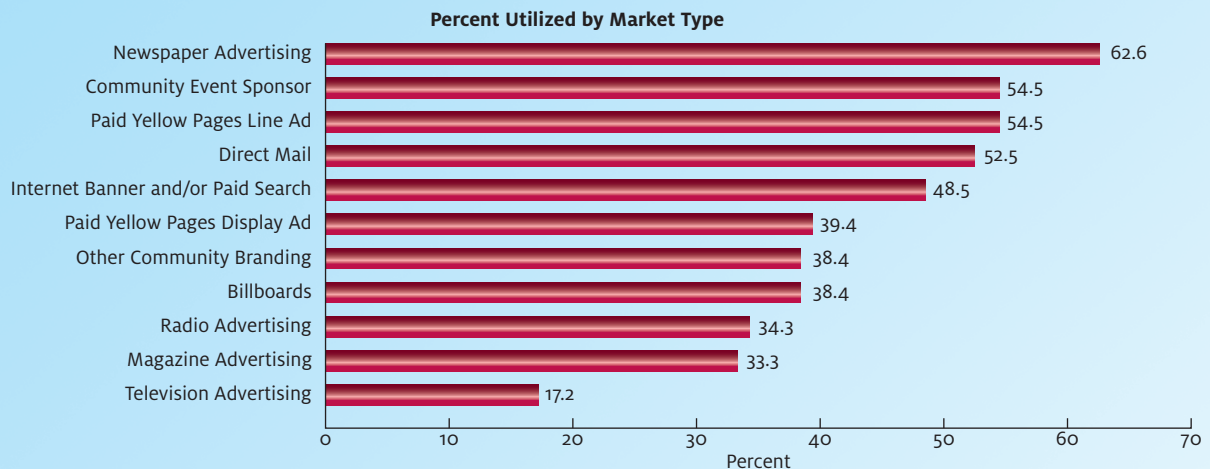


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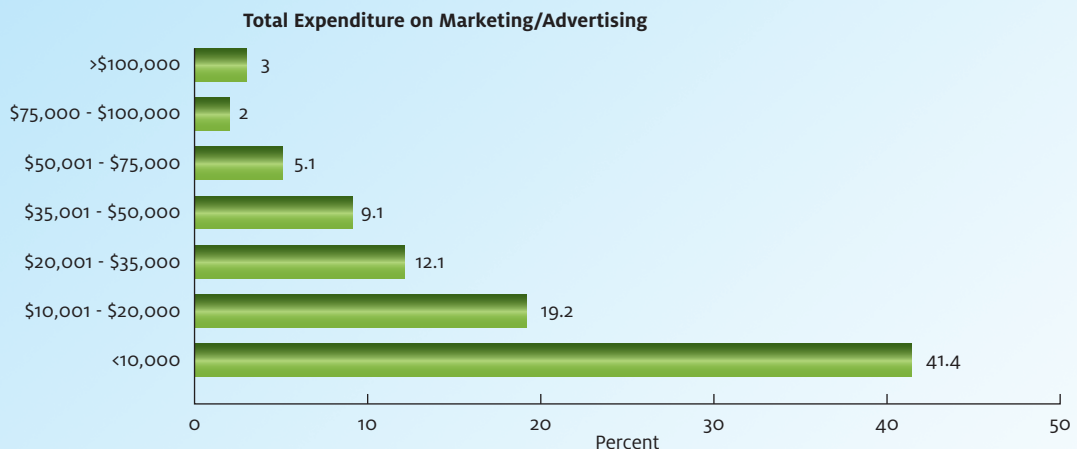
These data from the 2010 Urgent Care Benchmarking Survey are based on responses of 1,691 US urgent care centers; 32% were UCAOA members. The survey was limited to “full-fledged urgent care centers” accepting walk-ins during all hours of operation; having a licensed provider and x-ray and lab equipment on-site; the ability to administer IV fluids and perform minor procedures; and having minimal business hours of seven days per week, four hours per day.

In this issue: What types of marketing are utilized by urgent cares and what are the annual expenditures for marketing/advertising?

URGENT CARE ADVERTISING AND MARKETING



Marketing can take many forms. The chart above shows the utilization levels by urgent cares of different types of advertising and outreach to promote their centers and acquire new patients.



More than 40% of urgent cares spend less than \$10,000 per year on marketing/advertising. As competition for patients grows keener, expect those expenditures to grow.

Acknowledgement: The 2010 Urgent Care Benchmarking Study was funded by the Urgent Care Association of America and administered by Professional Research Associates, based in Omaha, NE. The full 40-page report can be purchased at www.ucaoa.org/benchmarking.

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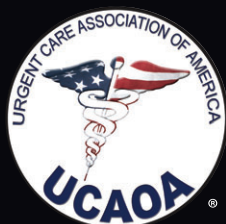
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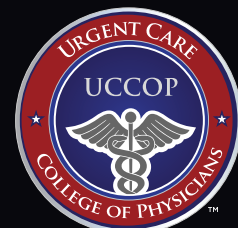
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