CLINICAL FOCUS

Epididymitis

The Optimal Urologic Evaluation Management Approach in the Urgent Care Setting
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LETTER FROM THE EDITOR-IN-CHIEF

Keeping the Joy of Practice

M any physicians in urgent care face burnout. While the numbers are probably far less than our emergency medicine colleagues, the burdens of productivity, quality, patient satisfaction, employee satisfaction, and risk management can weigh heavily on urgent care physicians, and with time, take the joy out of practicing. This is the first in a series of editorials providing practical tips for reducing “urgent care fatigue syndrome.”

Let’s start with an approach to managing patients who are antibiotic and narcotic seekers: make a dent in the armor / you can’t win the war in one visit / live to fight another day. Attempting to right all the wrongs in the world is a surefire way to burn out or lose your job to poor productivity.

Case 1: ‘Recurrent Sinusitis’

This patient arrives in the urgent care for “recurrent sinusitis,” but it becomes clear during the history that this patient is undoubtedly receiving multiple courses of antibiotics inappropriately, has never had an appropriate work-up, and has never been given an evidence-based treatment plan. She has been conditioned to pursue antibiotics when she feels this way.

You could do “battle” with this patient on inappropriate antibiotics, but I can guarantee you she will reject your theory and go to other caregivers who will make you look bad by giving her the antibiotics anyway. You will have accomplished nothing by way of reducing antibiotic use this way. Here’s an alternative that will save you the speech, and maybe recruit her onto the side of sensible antibiotic use:

“You seem frustrated that you keep getting ‘sinus infections’ requiring multiple courses of antibiotics. I think we need to recruit a specialist to help find out why, and to develop a treatment plan for whenever you get ‘sinus symptoms’ so you don’t develop resistance, but still get appropriate treatment when you need it. Ask the specialist exactly when you should start antibiotics and when you should just treat symptomatically. We need to give you more clear guidance, so that you can feel sure you are getting the most appropriate treatment.”

Even if you give this patient an antibiotic this time, you have made a dent in her psyche without offending her. Referring this patient to an ENT whom you trust will provide her with a long-term management plan that is consistent with established guidelines.

Case 2: Migraine Headache, ‘Needs Demerol’

Everyone dreads this encounter, but this is an opportunity to impact this patient’s care for the future.

I have found that the majority of these patients are victims of poor medical care, and are not drug seekers. They have been conditioned by providers who have never explained migraine management or the importance of a treatment plan from a migraine specialist. Most of these patients are indeed out of the window for effective triptan use anyway.

After thorough neurologic evaluation for alternative causes, I say this: “The use of narcotics for migraines is a last resort for most patients. I am concerned that you have not been given an effective prevention and treatment plan for your migraines, which may be contributing to your frequent, debilitating attacks. Because narcotics are rarely used for migraine management, we have a policy requiring an order from a headache specialist highlighting your treatment plan, should they be necessary on an ongoing basis.”

This avoids the battle, presumes innocence, and protects against the real drug seekers. At our clinics, we have no return offenders with this policy and never meet any resistance from patients. Most are simply grateful that we took a genuine interest in their well-being. The same approach can be taken for the other common narcotic requestor: the “back pain” patient.

In future editorials, I will address the following important contributors to career durability and satisfaction:

- Understanding patient agendas
- Communication tools for more effective patient encounters
- Filling your “emotional tank”

Sincerely,

Lee A. Resnick, MD
Editor-in-Chief

JUCM, The Journal of Urgent Care Medicine
Epididymitis: The Optimal Urologic Evaluation Management Approach in the Urgent Care Setting

Distress over bothersome symptoms is driving increasing numbers of men to urgent care for evaluation and treatment of epididymitis, making it imperative that providers understand the proper approach to management.

By Richard A. Schoor, MD, FACS

Emergencies in the Office: Why Are 911 Calls Placed From Family Medicine and Urgent Care Offices?

The decision to call—or not call—911 for a patient in the urgent care clinic is a crucial one for all providers. Exclusive new data indicate that clinicians make the call based on a wide range of criteria.

By Robert J. Dachs, MD, FAAFP, Ephraim Back, MD, FAAFP, and Brian Glick, PA-C, FAAPA, NREMT-P
When cough shows up in your urgent care center...

Reach for Tussionex®

Among prescription antitussives,

Only Tussionex® provides proven 12-hour cough relief*

TUSSIONEX® is indicated for relief of cough and upper respiratory symptoms associated with allergy or a cold. Each teaspoonful (5 mL) of TUSSIONEX® contains hydrocodone polistirex equivalent to 10 mg hydrocodone bitartrate and chlorpheniramine polistirex equivalent to 8 mg chlorpheniramine maleate.

TUSSIONEX® is contraindicated in the presence of known allergy to hydrocodone or chlorpheniramine. The most common adverse reactions associated with TUSSIONEX® are sedation, drowsiness, and mental clouding, which may impair the mental and/or physical abilities required for potentially hazardous tasks.

As with other drugs in this class, the possibility of tolerance and/or dependence, particularly in patients with a history of drug dependence, should be considered.

*Based on pharmacokinetic data.
Reference: 1. Data on file, UCB, Inc.
Please see adjacent page for full Prescribing Information.
Chlorpheniramine Polistirex: sulfonated styrene-divinylbenzene copolymer complex with 2-\(\beta\)-methoxy-17-methylmorphinan-6-one.

α-Hydrocodone Polistirex: sulfonated styrene-divinylbenzene copolymer complex with 4,5-epoxy-3\(\beta\)-chloro-17\(\beta\)-methylmorphinan-6-one.

Chlorpheniramine is an antihistamine drug (H1 receptor antagonist) that also possesses anticholinergic and sedative activity. It prevents released histamine from dilating capillaries and causing edema of the respiratory mucosa.

Hydrocodone release from Tussionex® Pennkinetic Extended-Release Suspension is controlled by the Pennkinetic System, an extended-release drug delivery system which combines an ion-exchange polymer matrix with a diffusion rate-limiting permeable coating. Chlorpheniramine release is prolonged by use of an ion-exchange polymer system.

Following multiple dosing with Tussionex® Pennkinetic Extended-Release Suspension, hydrocodone mean (S.D.) peak plasma concentrations of 22.8 (5.9) ng/mL occurred at 3.4 hours. Chlorpheniramine mean (S.D.) peak plasma concentrations of 58.4 (14.7) ng/mL occurred at 6.3 hours following multiple dosing. Peak plasma levels obtained with an immediate-release syrup occurred at approximately 1.5 hours for hydrocodone and 2.8 hours for chlorpheniramine. The plasma half-lives of hydrocodone and chlorpheniramine have been reported to be approximately 4 and 16 hours, respectively.

INDICATIONS AND USAGE: Tussionex® Pennkinetic Extended-Release Suspension is indicated for relief of cough and upper respiratory symptoms associated with or a cold.

CONTRAINDICATIONS: Known allergy or sensitivity to hydrocodone or chlorpheniramine.

WARNINGS: Respiratory Depression: As with all narcotics, Tussionex® Pennkinetic Extended-Release Suspension produces dose-related respiratory depression by directly acting on brain stem respiratory centers. Hydrocodone affects the center that controls respiratory rhythm, and may produce irregular and periodic breathing. Caution should be exercised when Tussionex® Pennkinetic Extended-Release Suspension is used concomitantly with other CNS depressants or in patients with respiratory disease or when respiratory function is impaired. Respiratory depression occurs, it may be antagonized by the use of an exchange polymer system.

Hyponatremia and Increased Intracranial Pressure: The respiratory depressive effects of narcotics and their capacity to elevate cerebral fluid pressure may be markedly exaggerated in the presence of a head injury, especially a intracranial lesion or a pre-existing increase in intracranial pressure. Furthermore, narcotics produce adverse reactions which may obscure the clinical course of patients with head injuries.

Acute Abdominal Conditions: The administration of narcotics may obscure the diagnosis or clinical course of patients with acute abdominal conditions.

Obstructive Bowel Disease: Chronic use of narcotics may result in obstructive bowel disease especially in patients with underlying intestinal motility disorder.

Pediatric Use: In pediatric patients, as well as adults, the respiratory center is sensitive to the depressive action of narcotics and the potential for respiratory depression increases in infants and in the presence of CNS depressants or when respiratory disease is present.

PRECAUTIONS: General: Caution is advised when prescribing this drug to patients with narrow-angle glaucoma, asthma or prostatic hypertrophy.

Special Risk Patients: As with any narcotic agent, Tussionex® Pennkinetic Extended-Release Suspension should be used with caution in elderly or debilitated patients and those with severe impairment of hepatic or renal function, and those patients with a history of head injury.

Information for Patients: As with all narcotics, Tussionex® Pennkinetic Extended-Release Suspension may produce drowsiness and impair the mental and physical abilities required for the performance of potentially hazardous tasks, such as driving a car or operating machinery; patients should be cautioned accordingly. If Tussionex® Pennkinetic Extended-Release Suspension is used postoperatively, patients may experience additional effects, such as drowsiness, and side effects may be increased. This may affect the pain reliefRnd and lengthen the absorption rate, possibly increasing the toxicity. Keep out of the reach of children.

Cough Reflex: Hydrocodone suppresses the cough reflex; as with all narcotics, caution should be exercised when Tussionex® Pennkinetic Extended-Release Suspension is used postoperatively, and in patients with pulmonary disease.

Drug Interactions: Patients receiving narcotics, hydrocodone, and chlorpheniramine, antidepressants or other CNS depressants (including alcohol) should be carefully monitored with Tussionex® Pennkinetic Extended-Release Suspension. These drugs interact to produce an increased respiratory depression. When combined therapy is contemplated, the dose of one or both agents should be reduced.

The use of MAO inhibitors or tricyclic antidepressants with hydrocodone preparations may increase the potential for respiratory depression. The concurrent use of other anticholinergics with hydrocodone may produce paralytic ileus.

Carcinogenesis, Mutagenesis, Impairment of Fertility: Carcinogenicity, mutagenicity and reproductive studies have been conducted with Tussionex® Pennkinetic (hydrocodone polistirex and chlorpheniramine polistirex) Extended-Release Suspension.

Pregnancy: Teratogenic Effects — Pregnancy Category C. Hydrocodone has been shown to be teratogenic when given in dosages to pregnant rabbits at doses which produced maternal toxicity. However, human experience is limited to a small number of uncontrolled studies in pregnant women. Tussionex® Pennkinetic Extended-Release Suspension should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nonteratogenic Effects: Babies born to mothers who have been taking opioids regularly prior to delivery will be physically dependent. The withdrawal signs include irritability and excessive crying, tremors, hyperactive reflexes, increased respiratory rate, increased sweating, sneezing, yawning, vomiting and fever. The intensity of the syndrome does not always correlate with the duration of maternal opioid use or dose.

Labor and Delivery: As with all narcotics, administration of Tussionex® Pennkinetic Extended-Release Suspension to the mother shortly before delivery may result in some degree of respiratory depression in the newborn, especially if higher doses are used.

Nursing Mothers: It is not known whether this drug is secreted in human milk. Because many drugs are excreted in human milk, caution should be exercised when Tussionex® Pennkinetic Extended-Release Suspension is administered to a nursing woman.

CLINICAL PHARMACOLOGY: Hydrocodone is a semisynthetic narcotic antitussive and analgesic with multiple actions qualitatively similar to those of codeine. The precise mechanism of action of hydrocodone and other opiates is not known; however, hydrocodone is believed to act directly on the cough center. In excessive doses, hydrocodone, like other opium derivatives, will depress respiration.

It is claimed that the effects on the cardiovascular system are insignificant. Hydrocodone can produce miosis, euphoria, physical and psychological dependence.

Carcinogenesis, Mutagenesis, Impairment of Fertility: Carcinogenicity, mutagenicity and reproductive studies have not been conducted with Tussionex® Pennkinetic (hydrocodone polistirex and chlorpheniramine polistirex) Extended-Release Suspension.

DRUG ABUSE AND DEPENDENCE: Tussionex® Pennkinetic Extended-Release Suspension is a Schedule II narcotic. Psychic dependence, physical dependence and tolerance may develop upon repeated administration of narcotics; therefore, Tussionex® Pennkinetic Extended-Release Suspension should be prescribed and administered with caution. However, psychic dependence is unlikely to develop when Tussionex® Pennkinetic Extended-Release Suspension is used for a short time for the treatment of cough. Physical dependence, the condition in which continued administration of the drug is required to prevent the appearance of a withdrawal syndrome, assumes clinically significant proportions only after several weeks of continued oral narcotic use, although some mild degree of physical dependence may develop after a few days of narcotic therapy.

OVERDOSAGE: Signs and Symptoms: Serious overdose with hydrocodone is characterized by respiratory depression (a decreased respiratory rate and/or respirations, Cheyne-Stokes respiration, cyanosis), extreme semiconsciousness progressing to stupor or coma, skeletal muscle flaccidity, cold and clammy skin, hypothermia, secretions, bronchoconstriction, and sometimes bradycardia. Administer naloxone hydrochloride. Naloxone does not affect the hypotension or respiratory depression which may result from overdose or unusual sensitivity to narcotics including hydrocodone. Therefore, an appropriate dose of naloxone hydrochloride should be administered, preferably by the intravenous route, simultaneously with efforts at respiratory resuscitation. Since the duration of action of hydrocodone in this formulation may exceed that of the antagonist, the patient should be kept under continued surveillance and repeated doses of the antagonist should be administered as needed to maintain adequate respiration. For further information, see full prescribing information for naloxone hydrochloride. An antagonist should not be administered in the absence of clinically significant respiratory depression. Oxygen, intravenous fluids, vasopressors and other supportive measures should be employed as indicated. Gastric emptying may be useful in removing unabsorbed drug.

DOSAGE AND ADMINISTRATION: Shake well before using.

Adults: 1 teaspoonful (5 mL) every 12 hours; do not exceed 2 teaspoonfuls in 24 hours.

Children: 6-12: 1/2 teaspoonful every 12 hours; do not exceed 3 teaspoonfuls in 24 hours.

Not recommended for children under 6 years of age (see PRECAUTIONS).

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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.

JUCM The Journal of Urgent Care Medicine (www.jucm.com) is published through a partnership between Braveheart Publishing (www.braveheart-group.com) and the Urgent Care Association of America (www.ucaoa.org).
Richard A. Schoor, MD, FACS, who penned our lead clinical article this month, is widely published as the author of scientific papers on topics concerning male infertility, urinary tract infections, and computational neural network modeling, as well as numerous textbook chapters on urologic subjects.

In private practice in Smithtown, NY, Dr. Schoor is certified by the American Board of Urology and is an active member of the American Urologic Association, The American Society of Andrology, The American Society of Reproductive Medicine, and The American College of Surgeons. His first contribution to JUCM, Epididymitis: The Optimal Urologic Evaluation Management Approach in the Urgent Care Setting begins on page 10.

We’re also indebted to Robert J. Dachs, MD, FAAFP, Ephraim E. Back, MD, MPH, FAAFP, and Brian H. Glick, PA-C, FAAPA, NREMT-P for contributing the first piece of original research we’ve had the privilege of publishing. Their article on what cases move urgent care centers to call 911 on behalf of patients in their care begins on page 19; it compares data from urgent care centers with that gleaned from family practice offices.

To our knowledge, this represents the first such research specific to urgent care. All three of the authors practice at St. Clare’s Hospital in Schenectady, NY; Dr. Dachs is assistant director of the Department of Emergency Medicine, as well as clinical assistant professor of St. Clare’s Family Medicine Residency Program, Albany Medical College; Dr. Back is chief of the Department of Family Medicine and associate director of the Family Practice Residency Program, while also serving as clinical associate professor of family and community medicine at Albany Medical College, and Mr. Glick is a PA in emergency medicine and volunteers as a paramedic with the Clifton Park & Halfmoon Emergency Corps, of which he has been chairman of the board for the past five years.

Of course, we continue to appreciate the contributions of Nahum Kovalski, BSc, MDCM of Terem Immediate Medical Care in Jerusalem, Israel; John Shufeldt, MD, MD, MBA, FACEP, CEO of NextCare, Inc.; Frank Leone, MBA, MPH, president and CEO of RYAN Associates as well as founder and executive director of the National Association of Occupational Health Professionals; and David Stern, MD, CPC, a partner in Physicians Immediate Care and chief executive officer of Practice Velocity, who have contributed their time and expertise to each of the first three issues of JUCM.

The Clinical Challenges for this issue (pages 29-32) were contributed by Drs. Scott Fields, Aryeh Poms, Rafold Livshin, and Uri Frankl.

As always, all this transpires under the watchful eye of our editor-in-chief, Lee Resnick, MD, who is medical director of University Hospitals Urgent Care (University Hospitals Medical Practice, Inc.), and assistant clinical professor in the Department of Family Medicine at University Hospitals Case Medical Center in Cleveland, as well as a member of the Board of Directors and the chair of academics for UCAOA.

If you’d like to take an active part in shaping what you read in JUCM, let us know what you think by e-mailing a Letter to the Editor to editor@jucm.com.
Shooting for Great or Trying to Survive?

LOU ELLEN HORWITZ

“We have met the enemy, and he is us.”

Walt Kelly, Pogo

If you have read Jim Collins’ book, Good to Great, then you have learned why the true enemy of being a great organization may be trying to be “good” at too many things. Our efforts to be competitive with all comers can sometimes blind us to the unique qualities we have that make us great.

Let me give you an example.

Let’s say Main Street Urgent Care has been open for about 18 months when the big-box retailer down the street opens a walk-in clinic in the space where the video rental department used to be. The physician/owner of Main Street is concerned that the low-cost visits offered by the new clinic will lure patients away.

What would you do? Would you scale back on your physician caregivers and add more nurse practitioners so you can offer some of the same low-cost visits without losing your shirt? Would you run a negative ad campaign depicting the retail clinic as providing “inferior medical care” and run by an uncaring corporation? Would you close down Main Street and buy into one of the retail clinics? Would you think, “How can we get good at what they are good at so we can compete with them?”

While all of these are options, what Collins argues is that these kinds of “threats” are an opportunity to reanalyze (or discover) what he calls your “Hedgehog Concept”—what it is that Main Street Urgent Care can be the best in the world at doing.

If right now you are not the best in the world (or at least in your community) at anything, then the new retail clinic may indeed be a threat to you and you need to make some adjustments. If you are the very best in your community at delivering the care that your patients need when they want it, in the way that they want it, then you will probably weather the retail clinic’s arrival just fine (anecdotal evidence indicates that many have done just that).

If you don’t know if you are the best at anything, then it’s time to get your team together and have some vigorous discussions about what you can be the best at, and get to work on whatever that turns out to be (and then market it!). It’s not a fast process, nor generally an easy one, so even if you are still the only urgent care center in your market, the time to think about your “hedgehog concept” is now, before competition starts to hone in on your patients. At UCAOA, we get at least one e-mail a week from owners who are about to open a new clinic; it’s only a matter of time before one of them opens in your territory.

A Whole New Mind

The second enemy of great may be our natural tendency to continue thinking about our business the way we always have. We focus on how we can improve our turnaround times, better predict staffing needs, increase collection rates, etc. Meanwhile, patients are self-diagnosing using criteria gleaned from the Internet, more and more treatments are becoming available over the counter, new models for who can prescribe treatment are emerging, radiology films are being read by practitioners in India, and consumers are demanding different levels of service than in the past.

With these rapid evolutions in the delivery of healthcare, medicine is well on its way to becoming a commodity, and while urgent care providers may not be influenced as quickly as a solo practitioner, we are not immune.

At the same time, the medical community is struggling to keep pace with pharmacological advances, new technologies, and the limited hours available in the day to see patients. With so many day-to-day issues, how do you, as a clinic leader, focus your efforts and your resources?
“We have experienced a dramatic improvement in E&M coding as a result of using Practice Velocity PiVoTs. This case mix shift has significantly softened the impact of the new Illinois Workers’ Compensation Fee Schedule as of 2/1/2006.”

Peter T. Lynch
Director of Billing and Systems Administration,
Alexian Brothers Corporate Health Services
Schaumburg, IL

“Hands down the best program out there for Urgent Care clinics! This is by far the most user friendly software I have ever used.”

Tara Toomer
Clinic Administrator,
Juneau Urgent Care
Juneau, AK
As we have learned from watching the ramifications of the Institute of Medicine’s reports on medical errors, quality medical care is the price of entry in our field—it’s the bare minimum requirement for even opening your doors. It just makes sense that is where your focus must be.

After quality care (which we hope was already your focus), you need to look at what will make you stand out in your community (with patients, employers and other “customers”). More and more research is indicating that what Daniel Pink, best-selling author of *A Whole New Mind*, calls “high concept, high touch” is influencing both consumer choice and even medical training. Students at institutions like Columbia University Medical School, Yale School of Medicine, and UCLA Medical School are all being trained not only in traditional clinical skills but also in empathy, observation, and spirituality. Jefferson Medical School even measures its physicians’ “empathy index.”2 (Is that part of your compensation formula?)

So, what is the patient experience like in a typical visit to your clinic? Is your front desk staff busy pushing paper, primarily, or are they able to use higher-level discretionary skills to make patients feel welcome, calm, attended to, and generally in good hands? Are your clinicians trained in conversing effectively with patients to avoid overlooking an underlying concern beyond the presenting problem? If many of your patients are from a different cultural background than your own, have you done any research or training about sensitivities you and your staff should be aware of?

In short, are your patients walking out the door (and into the community) feeling pleasantly surprised at how fantastic the care was at your center, or are they thinking that it “wasn’t too bad” for a walk-in place?

As technology replaces the human touch in more and more activities, we will all need to capitalize on the skills that only humans can deliver: the simple act of being human to one another. While most of us are delighted to bypass the human element while checking in for our airline flight, when it comes to our health we want another thing entirely—to have a qualified group of people who care for our well-being helping us to get better.

If your clinic isn’t getting that message across, then you are not going to be a great urgent care center, no matter how exemplary your clinical care is. Find a way to give that message to your patients, and let your next big worry be how to invest your profits.

References

Clinical Focus

Epididymitis
The Optimal Urologic Evaluation Management Approach in the Urgent Care Setting

Urgent message: Though epididymitis is clinically non-urgent, its symptoms are driving more and more men to urgent care, making it imperative that providers are familiar with its epidemiology, etiology, evaluation, and treatment.

Richard A. Schoor, MD, FACS, Private Practitioner, Smithtown, NY

Introduction

Epididymitis is among the most frequently diagnosed and treated conditions in men. Typically, men present to, and are diagnosed and treated by, their primary care physicians or their urologist. Treatment is with antibiotics on an outpatient basis. Epididymitis is, in general, non-life threatening and non-urgent. However, afflicted patients experience significant distress from the symptoms and tend to seek treatment early.

Urgent care medicine is emerging as a distinct specialty, separate from both emergency medicine and primary care. From a patient’s perspective, an urgent care office visit would be an attractive alternative to an emergency room visit for a variety of reasons, especially if the patient perceives his symptoms to be non-life threatening, but is concerned nonetheless to the point of wanting immediate medical attention without long waits and other unpleasantries associated with an emergency department visit.

Epididymitis, for the most part, fits this description well and has become commonplace in urgent care centers. Therefore, it is imperative that urgent care physicians understand the epidemiology, etiology, evaluation, and therapy of epididymitis.

Etiology and Epidemiology

Sperm is produced in the testicle and matures in the epididymis, a long convoluted tube that sits adjacent to the testicle. From the epididymes, the sperm is transported via the vas deferens to the ejaculatory duct, in the prostatic urethra. It is at this location that infected urethral urine may access the male reproductive tract, ascend to the epididymis, and cause epididymitis. Sterile urine can also reflux up these ducts and cause a reactive, chemical epididymitis.

Epididymitis connotes inflammation of the epi-
didymis, an accessory gland in the male reproductive tract. Classically, the inflammatory process is the result of bacterial infection, but it can be caused by viruses or reflux of sterile urine up the reproductive tract.

In men less than 35-years-old, *Chlamydia* is the likely agent, thus making epididymitis in this group a sexually transmitted disease. In men greater than 35-years-old, *E coli* is the most commonly isolated pathogen. Hematogenous spread of bacteria is rare, but can occur with tuberculosis. True bacterial epididymitis in older men or children is typically associated with an anatomic abnormality, such as bladder outlet obstruction or a congenital urologic anomaly, such as an ectopic ureter.

Viral infection (e.g., mumps) may also cause epididymitis. Mumps epididymal orchitis is more common in the post-pubertal, pediatric population but has become uncommon due to the routine use of the mumps vaccine. Fungal infections may also cause epididymitis, most notably in the immunocompromised. Other causes of epididymitis include medications (amiodarone), vascular ulititis (Henoch-Schönlein purpura), and parasites.

Epididymitis affects one in 350 U.S. men annually and has no race predilection.

**Diagnosis**

**History and Physical Examination**

Men with epididymitis present with scrotal or testicular pain that can range from a mild, achy discomfort to severe pain with associated high fever and a leukocytosis. Men with the latter will most commonly present to an emergency department due to the severity of their symptoms and will occasionally require admission for intravenous antibiotics.

In an ambulatory setting, men more commonly present with milder complaints of testicular or scrotal pain. Occasionally, they will have dysuria or urinary frequency suggestive of a urinary tract infection (UTI), though often voiding symptoms will be absent.

A comprehensive medical history should be performed and specifically include a urologic history. The patient’s use of safe sex practices, or lack thereof.

A physical examination of the scrotum, testicles, and epididymis is to be done and will likely demonstrate tenderness over the involved epididymis. In severe cases, fluctuance is present. Occasionally, epididymitis will cause a reactive hydrocele to form and when large enough, the hydrocele will impair physical examination and prevent accurate diagnosis.

In this case, a scrotal sonogram is indicated. It is important to exam the testicles, as well, and to determine whether or not the acute scrotal pain is caused by testicular torsion or tumors, the two most serious diagnoses in the differential. The involved testicle in men with torsion will be very tender and have an abnormal transverse lie within the scrotum and the ipsilateral cremaster reflex will be absent, in general.

When testis torsion is suspected, the patient should be sent to an emergency department for immediate urologic consultation and, if need be, surgical detorsion.

**Adjunctive Tests**

Readily available adjunctive tests, when added to a comprehensive history and physical, can suggest or rule out the more serious conditions in the differential diagnosis. The urine analysis should be the first adjunctive test performed, and in severe cases of epididymitis will show pyuria. While the presence of pyuria suggests the diagnosis of epididymitis, it is not diagnostic and its absence does not rule out the diagnosis since patients can have fairly severe cases of epididymitis without urinary findings.

A urine culture should be performed, as well. The clean-catch method is the preferred technique, especially in the uncircumcised male, in whom preputial microbes can contaminate a urine specimen. The clean-catch technique involves instructing the man to retract his foreskin (if present) and clean the glans penis with an aseptic towelette, and then void midstream into the sterile collection cup. This technique should be used routinely in the urgent care setting and provides accurate urine culture results in men with minimal specimen contamination risk.

Alternatively, the three-glass cycle collection technique is optimal (Figure 1). In the three-glass cycle, the patient is asked to clean as above, and then to void the first 10 cc of urine into cup A, and the rest into cup B. The third specimen is collected into a sterile cup after the physician performs a prostate examination. This method can enable the physician to localize the source of the infection to the urethra (glass A),...
the bladder, (glass B), or the prostate (glass C). While the three-glass cycle is optimal, it is somewhat cumbersome to perform and is not routinely used nor mandatory in the urgent care setting.

A relatively new urine test that can detect Neisseria gonorrhoea (GC) and Chlamydia in the urine via DNA amplification, the BD ProbeTec™ (Quest Diagnostics), is also available. It uses polymerase chain reaction (PCR) technology to detect GC and chlamydial DNA fragments in the urine of patients with suspected STDs.12-14

Other highly sensitive and specific PCR-based tests are also available. Men are simply asked to void into a sterile collection cup, and the urine is transferred to the preservative-containing transport tube with a pipette. No urethral swab is needed. Since epididymitis in young men is considered an STD and most commonly caused by chlamydial infection, the DNA urine probe has become a useful adjunct in the diagnosis and treatment of epididymitis.

Scrotal Sonogram

Perhaps the single most important adjunctive test is the scrotal sonogram.15-17 The scrotal sonogram is abundantly available, safe, painless to perform, and inexpensive and provides the most accurate diagnostic information relating to scrotal pathology. Sonograms will readily detect testicular tumors, even small, non-palpable ones, can visualize the testicle within a hydrocele, and has echo-features that are characteristic for epididymitis and orchitis. Most sonogram units today, even portable office-based units, have Doppler flow capabilities and are useful in ruling out the presence of testicular torsion.

However, if testicular torsion is even suspected, it is prudent for the evaluating physician to obtain a prompt urology consult or to send the patient immediately to the emergency room at a hospital that is equipped to handle this type of emergency.

Sonographically, epididymitis has findings that are suggestive, though not diagnostic, of the condition. These findings include hyperemia of the epididymes and surrounding testicle or epididymal engorgement. Often, a reactive hydrocele is present and can be seen on the sonogram. However, the most important sonographic findings are the absence of a testis mass and the presence of testicular blood flow on Doppler.16-17

Cautionary Notes

The clinician should bear the following cautions in mind at all times:

- The presence of Doppler flow in the testicle does not completely rule out testis torsion. In cases of suspected torsion, urologic consultation is mandatory.
- Epididymitis is uncommon in prepubertal boys. Acute scrotal pain in this population should be considered torsion until proven otherwise.
- Bacterial epididymitis in the pediatric population represents a urinary tract infection and needs to be evaluated appropriately.

Therapy

The treatment of epididymitis depends on a variety of factors that include the age of the patient, the severity of the presentation, and the patient's medical history.

In young adults or in patients at risk for an STD, ceftriaxone sodium and doxycycline are the preferred agents due to their efficacy against Neisseria gonorrhoea and Chlamydia. Ceftriaxone is given as a one-time dose, but doxycycline must be given for seven to 14 days, which can adversely affect compliance.

Alternatively, the treating physician may prescribe azithromycin, which is advantageous over ceftriaxone sodium and doxycycline with regard to both its
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Antimicrobial spectrum of activity and for patient compliance.

Affected men should be counseled regarding the sexual transmissibility of the disease and their partners should be evaluated. In addition, it is prudent for the treating physician to discuss safe sex practices and barrier protection with the patient and to document the discussion in the medical record. Resumption of unprotected sexual intercourse with untreated partners is a vehicle for reinfection.

In older men, among whom E. coli from either cystitis or a bacterial prostatitis source is the most common uropathogen, treatment with a fluoroquinolone antibiotic is preferred. The fluoroquinolone class of antibiotics is optimal due to the pharmacological properties of these agents, which allow them to penetrate the male reproductive tract, specifically the prostate, in high bacteriocidal levels.

The quinolones are also effective in the presence of bacterial pseudomembranes and even biofilms. Other antibiotic classes, such as the penicillins, lack these important pharmaco-qualities and their usage, while acceptable, is associated with higher treatment failure rates and disease recurrence rates. The duration of therapy can range from 14 days to six weeks, depending upon the underlying etiology of the epididymitis, its severity, and its responsiveness to treatment. For example, in men whose epididymitis was caused by an underlying bacterial prostatitis, an extended four-to-six-week treatment period is indicated.

In the pediatric population, epididymitis is considered a UTI and is treated as appropriate. In general,
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Epididymitis

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a course of an antibiotic such as sulfamethoxazole/trimethoprim, nitrofurantoin, or amoxicillin can be given with a patient referral to a urologist or pediatric urologist. Quinolones are contraindicated for use in children in the United States due to perceived issues relating to cartilage growth. In addition, doxycycline can cause permanent teeth staining and must not be used in the pediatric population.

See Figure 2 for an algorithm regarding optimal evaluation and management of acute scrotal pain and epididymitis in the urgent care setting.

Follow-up

Patients with acute epididymitis do well and the condition typically resolves without sequelae when treated appropriately. Young men with the STD variant of epididymitis can expect rapid improvement in their symptoms in a matter of one to two days, though this rapid improvement occasionally results in treatment non-compliance and recurrences. Rarely, men with inadequately treated epididymitis can develop infertility due to epididymal obstruction as a late complication. This process is analogous to pelvic inflammatory disease in women.

Patients should be seen back in the office in two weeks, at which time compliance is assessed and follow-up cultures are performed. After this, patients can be seen on a PRN basis.

Pediatric patients with epididymitis should be referred to a urologist or, if available, a pediatric urologist for follow-up.

Older men with the E.coli-induced epididymitis, likewise, do very well after antimicrobial therapy. Patients should be followed up in two to three weeks to see if their pain has resolved. In addition, patients are instructed to call sooner if their symptoms do not improve or get worse.

Some cases of epididymitis are associated with reactive hydroceles, as previously mentioned; the hydroceles often take several weeks to months to resolve, if they resolve at all. Men with large persistent reactive hydroceles can be referred to a urologist for counseling and, if the hydrocele causes the man bother, surgical correction.

Lastly, some men develop a persistent nonspecific scrotal or epididymal pain after an episode of epididymitis. The etiology of this pain is unclear, but infection with standard uropathogens is unlikely. Men who complain of this type of complication are best referred to a urologist for evaluation and management that can include trials of NSAIDs, low-dose tri-cyclic antidepressants, and alpha-blocker therapy, among others.

Summary

Epididymitis is common and affects all ages without race predilection. Affected patients will have scrotal pain of varying severity and associated findings. After a thorough history and physical examination, adjunctive tests such as the UA and the scrotal sonogram may aid in the diagnosis. In young men, epididymitis is generally caused by GC or Chlamydia and is thus an STD. In older men, epididymitis is typically caused by E.coli and is thus a UTI. Boys with epididymitis are also viewed as having UTIs and are to be managed as such.

When treated appropriately, epididymitis resolves without sequelae in the majority of men.

REFERENCES

CIPRODEX® Otic twice per day according to label directions. Long term studies have not been performed to test systems gave negative results:
Chinese Hamster V79 Cell HGPRT Test (Negative), Syrian Hamster Embryo Cell Transformation Assay (E. coli/Microsome Test (Negative), Salmonella). E. coli/Microsome Test (Negative), Salmonella.

Even if the symptoms improve, contact your physician. It is very important to use the ear drops for as long as the doctor has instructed, even if the patient is not aware of any symptoms or signs of improvement. The drug is active for 48 to 72 hours after application, and if therapy is discontinued, the ear should be cleaned again, and therapy should be continued until it is symptom-free.

Specific drug interaction studies have not been conducted with CIPRODEX® Otic.

For children, the recommended dosage in cases of acute otitis media is 2 drops of CIPRODEX® Otic, 1 mL of the ointment, or 5 mL of the suspension, twice daily for seven days. The solution should be warmed by holding the bottle in the hand for one or two minutes to avoid dizziness, which may result from the instillation of a cold solution. The patient should lie with the affected ear upward, and then the drops should be instilled. The drug should then be pumped 5 times by pressing in to facilitate penetration of the drops into the middle ear. This position should be maintained for 45 seconds. Repeat, if necessary, for the opposite ear.

For adults, CIPRODEX® Otic in patients with acute otitis externa, the solution should be warmed by holding the bottle in the hand for one or two minutes to avoid dizziness which may result from the instillation of a cold solution. The patient should lie with the affected ear upward, and then the drops should be instilled. The drug should then be pumped 5 times by pressing in to facilitate penetration of the drops into the middle ear. This position should be maintained for 45 seconds. Repeat, if necessary, for the opposite ear.

DOSAGE AND ADMINISTRATION

CIPRODEX® Otic should be shaken well immediately before use.

Acute Otitis Media in pediatric patients weighing 9 months and older is to be used in patients with acute otitis externa through tympanostomy tubes to allow for the treatment of acute otitis externa in pediatric patients (age 6 months and older). The drug should be instilled through the ear canal. Repeat, if necessary, for the opposite ear.

CIPRODEX® Otic should be used in patients with acute otitis externa through tympanostomy tubes to allow for the treatment of acute otitis externa in pediatric patients (age 6 months and older). The drug should be instilled through the ear canal. Repeat, if necessary, for the opposite ear.

The following treatment-related adverse events were each reported in a single patient: tympanostomy tube blockage; ear pruritus; tinnitus; oral moniliasis; crying; dizziness; and erythema.

Acute Otitis Externa: The following treatment-related adverse events occurred in 0.4% or more of the patients with intact tympanic membranes.

The following treatment-related adverse events were each reported in a single patient: ear discharge; rash; ear disorder (tingling).
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Original Research

Emergencies in the Office
Why Are 911 Calls Placed From Family Medicine and Urgent Care Offices?

Urgent message: New data indicate that calls to 911 from family medicine and urgent care offices and subsequent transport to ED occur for a wide range of reasons, with the distribution varying to a large degree based on the age of the patient and the practice setting.

Robert J. Dachs, MD, FAAFP, Ephraim Back, MD, FAAFP, Brian Glick, PA-C

Introduction
Life-threatening emergencies have been reported to occur in primary care medical offices. However, the type of medical emergencies that occur remains unclear. Previous studies that have attempted to evaluate emergencies taking place in physician offices have been hindered by recall bias and what defines a medical “emergency.” Heath et al demonstrated this problem when seven members of the same pediatric office staff were asked how many emergencies occurred during one year; one member estimated four, two estimated 50, and four reported 100 emergencies.

One would expect that the type of medical emergency encountered in the office setting would vary based upon the type of patient population cared for by a specific practice. For example, a prospective study of 38 pediatric practices in Vermont demonstrated that three-quarters of the emergencies were respiratory in origin. However, no data exist for any other patient population or practice setting.

The goal of this study was to evaluate what types of medical emergencies occur in family medicine and urgent care offices from a mix of urban, suburban, and rural practices in northeastern New York. By directly reviewing calls from these offices to the regional 911 system, the problem of recall bias and defining an “emergency” can be eliminated. An understanding of the types of emergencies that present to these practices may better prepare the family medicine and urgent care physician for such emergency situations in the future.

Methods
Thirty-four family medicine office locations and nine urgent care centers from Albany, Schenectady, and Saratoga counties of northeastern New York were iden-
Background: Previous studies have documented that medical emergencies can occur during a patient’s visit to a physician’s office. However, the types of patients and conditions that prompt a call to 911 from the primary care office have not been previously evaluated.

Methods: The authors abstracted the age, sex, and chief complaint of all 911 calls from 16 freestanding family medicine and six freestanding, privately owned urgent care practices in northeastern New York from January 1, 2002 through December 31, 2003. These practices represented a mix of urban, suburban, and rural practice locations.

Results: Seven hundred and six calls were made to 911 from the 22 practice locations during the study period: 90 calls originated from family medicine practices, with the remaining 396 calls coming from urgent care practices. Patients of all ages were noted, with the majority of calls made for adult patients (95.2% of all calls were for patients 20 years or older, 74.1% for patients 45 years or older, and 40.1% for patients 65 or older). The nature of complaints varied widely, with chest pain being the most common complaint (about one third of all calls). Respiratory conditions were the second most common reason (23.9% of all calls) for a 911 call from the office, and the most common reason for calls in patients younger than 20 years of age.

Conclusion: This study demonstrates that while older patients with chest pain and respiratory complaints dominate data regarding the types of emergencies encountered in family medicine and urgent care practices, a broad range of patients and medical conditions result in calls to 911 from these locations.

Table 1. Classification of Complaints Prompting 911 Call

| A. Unknown | No recorded complaint |
| B. Chest Pain | Chest pain or “heart attack” |
| C. Blood pressure | High or low blood pressure |
| D. Heart rate | Abnormal or irregular heart rate, palpitations, or dysrhythmia |
| E. EKG changes | EKG abnormalities |
| F. Respiratory | Dyspnea, airway compromise, asthma, COPD, or pneumonia |
| G. Abdominal pain | Abdominal or flank pain |
| H. Dehydration | Vomiting, diarrhea, or dehydration |
| I. Neurologic | Neurologic symptoms, dizziness, or headache |
| J. Psychiatric/toxicology | Psychiatric symptoms, overdoses, or toxic ingestions |
| K. Diabetes | Low or high blood sugar |
| L. Allergy | Allergic reactions, hives, or insect stings |
| M. Trauma | Trauma |
| N. OB/Gyn | Pregnancy-related complaints |
| O. CPR/cardiac arrest | Cardiac arrest and initiation of CPR |
| P. GI bleed | Gastrointestinal bleeding |
| Q. Fever/infectious disease | Febrile illness or need for antibiotic therapy |
| R. Syncope | Syncope or near syncope |

A review of all calls placed to 911 from the predefined medical practices over the study period (January 1, 2002 to December 31, 2003) was collected from the EMS records in the following New York communities: Albany, Bethlehem, Colonie, Berne, Guilderland, Schenectady, Niskayuna, Clifton Park, and Duanesburg. For each call, the following data were recorded: date and time of the call from the office, patient age and sex, and the chief complaint as documented by the EMS dispatcher. Complaints were classified according to the designated categories shown in Table 1. When more
than one chief complaint was recorded, such as “chest pain with shortness of breath,” both complaints were recorded in their predefined category.

Statistical analysis was performed using EpiInfo 2000 software (Centers for Disease Control, Atlanta, GA). Bivariate associations between practice type (family medicine or urgent care) and demographic or clinical variables were tested using the uncorrected $\chi^2$ test. Age difference among groups was analyzed with the ANOVA (analysis of variance between groups) test. A probability of less than 0.05 was considered significant. Odds ratios are not reported, as they did not add any additional information to this descriptive study.

The Institutional Review Boards of St. Clare’s Hospital, Schenectady, NY and the Regional Emergency Medical Organization (REMO) of Northeast New York approved the study protocol prior to initiation of the study.

**Results**

Of the 706 calls to 911 recorded, 310 came from family medicine offices and 396 from urgent care practices. In 102 cases, more than one chief complaint was recorded, resulting in a total of 808 complaints being documented. All patients for whom 911 was called were transported to an ED.

### Table 2. Age and Sex Distribution of Patients

<table>
<thead>
<tr>
<th>Demographic</th>
<th>Family Practice (n=310)</th>
<th>Urgent Care (n=396)</th>
<th>Total (n=706)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0-4</td>
<td>7 (2.3)</td>
<td>7 (1.8)</td>
<td>12 (2.0)</td>
</tr>
<tr>
<td>5-19</td>
<td>6 (1.9)</td>
<td>28 (7.0)</td>
<td>34 (4.8)</td>
</tr>
<tr>
<td>20-44</td>
<td>54 (17.4)</td>
<td>95 (23.9)</td>
<td>149 (21.0)</td>
</tr>
<tr>
<td>45-64</td>
<td>92 (29.7)</td>
<td>142 (35.7)</td>
<td>234 (33.1)</td>
</tr>
<tr>
<td>≥65</td>
<td>122 (39.4)</td>
<td>107 (26.9)</td>
<td>229 (32.3)</td>
</tr>
<tr>
<td>Not recorded</td>
<td>29 (9.4)</td>
<td>17 (4.3)</td>
<td>46 (6.5)</td>
</tr>
<tr>
<td>Mean age</td>
<td>58.1</td>
<td>51.5</td>
<td>54.2</td>
</tr>
<tr>
<td>Median age</td>
<td>60</td>
<td>52</td>
<td>54</td>
</tr>
<tr>
<td>Sex</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>131 (42.3)</td>
<td>178 (44.9)</td>
<td>309 (43.8)</td>
</tr>
<tr>
<td>Female</td>
<td>161 (51.9)</td>
<td>204 (51.5)</td>
<td>365 (51.7)</td>
</tr>
<tr>
<td>Not recorded</td>
<td>18 (5.8)</td>
<td>14 (3.5)</td>
<td>32 (4.5)</td>
</tr>
</tbody>
</table>

*P=0.0001

### Table 3. Number and Type of 911 Calls by Practice

<table>
<thead>
<tr>
<th>Type of 911 Call</th>
<th>Family Practice (n=310)</th>
<th>Urgent Care (n=396)</th>
<th>Total (n=706)</th>
<th>p value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chest pain</td>
<td>96 (25.5)</td>
<td>139 (32.3)</td>
<td>235 (29.1)</td>
<td>N/S</td>
</tr>
<tr>
<td>Respiratory</td>
<td>82 (21.8)</td>
<td>87 (20.1)</td>
<td>169 (20.9)</td>
<td>N/S</td>
</tr>
<tr>
<td>Neurologic</td>
<td>34 (9.0)</td>
<td>30 (6.9)</td>
<td>64 (7.9)</td>
<td>N/S</td>
</tr>
<tr>
<td>Abdominal pain</td>
<td>19 (5.1)</td>
<td>37 (8.6)</td>
<td>56 (6.9)</td>
<td>N/S</td>
</tr>
<tr>
<td>Trauma</td>
<td>9 (2.4)</td>
<td>38 (8.8)</td>
<td>47 (5.8)</td>
<td>0.0002</td>
</tr>
<tr>
<td>Heart rate</td>
<td>16 (4.8)</td>
<td>16 (3.7)</td>
<td>34 (4.2)</td>
<td>N/S</td>
</tr>
<tr>
<td>Miscellaneous</td>
<td>22 (5.9)</td>
<td>12 (2.8)</td>
<td>34 (4.2)</td>
<td>N/S</td>
</tr>
<tr>
<td>EKG changes</td>
<td>19 (5.1)</td>
<td>8 (1.9)</td>
<td>27 (3.2)</td>
<td>0.004</td>
</tr>
<tr>
<td>Syncope</td>
<td>11 (2.9)</td>
<td>16 (3.7)</td>
<td>27 (3.2)</td>
<td>N/S</td>
</tr>
<tr>
<td>Dehydration</td>
<td>13 (3.5)</td>
<td>9 (2.1)</td>
<td>22 (2.7)</td>
<td>N/S</td>
</tr>
<tr>
<td>Psychiatric/toxicology</td>
<td>14 (3.7)</td>
<td>6 (1.4)</td>
<td>20 (2.5)</td>
<td>0.015</td>
</tr>
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<td>Blood pressure</td>
<td>11 (2.9)</td>
<td>2 (0.5)</td>
<td>13 (1.6)</td>
<td>0.003</td>
</tr>
<tr>
<td>GI bleed</td>
<td>7 (1.9)</td>
<td>5 (1.2)</td>
<td>12 (1.5)</td>
<td>N/S</td>
</tr>
<tr>
<td>Diabetes</td>
<td>5 (1.3)</td>
<td>5 (1.2)</td>
<td>10 (1.2)</td>
<td>N/S</td>
</tr>
<tr>
<td>Allergy</td>
<td>4 (1.1)</td>
<td>5 (1.2)</td>
<td>9 (1.1)</td>
<td>N/S</td>
</tr>
<tr>
<td>Fever/infectious disease</td>
<td>2 (0.5)</td>
<td>7 (1.6)</td>
<td>9 (1.1)</td>
<td>N/S</td>
</tr>
<tr>
<td>Unknown</td>
<td>3 (0.8)</td>
<td>5 (1.2)</td>
<td>8 (1.0)</td>
<td>N/S</td>
</tr>
<tr>
<td>CPR</td>
<td>3 (0.8)</td>
<td>4 (0.9)</td>
<td>7 (0.9)</td>
<td>N/S</td>
</tr>
<tr>
<td>OB/Gyn</td>
<td>4 (1.1)</td>
<td>1 (0.2)</td>
<td>5 (0.6)</td>
<td>N/S</td>
</tr>
<tr>
<td>Total</td>
<td>376 (46.5)</td>
<td>432 (53.5)</td>
<td>808 (100.0)</td>
<td></td>
</tr>
</tbody>
</table>
EMR = ROI

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Age and Sex Distribution
The median age of patients for all calls was 54 years. Patients from urgent care practices who required EMS services were younger (median age=52) than were patients from family medicine offices requiring the same services (median age=60, p=0.0001). Table 2 shows the age distribution of all patients for whom 911 calls were made.

For calls in which sex was identified, 54.2% of patients were women and 45.8% were men. This finding is consistent with the data from the National Ambulatory Medical Care Survey (NAMCS) in 2001 that noted women accounted for 59.1% of all office visits.9

Reason for 911 calls
The complaints associated with all calls to 911 are noted in Table 3. The most frequent complaint leading to an EMS call to either family medicine or urgent care offices was chest pain, which accounted for one-third of all calls. Respiratory complaints accounted for almost one-quarter of calls. The types of conditions that initiated 911 calls were similar between family medicine and urgent care practices. Only trauma-related conditions were noted to be statistically more common in urgent care practices, while EMS calls for EKG changes, blood pressure abnormalities, and psychiatric and toxicologic conditions were statistically more common in family medicine practices.

Complaints were also stratified according to age (Table 4). Five age groups were defined as typical groupings: a) infant and young children (ages 0-4), b) older children and adolescents (ages 5-19), c) young adults (age 20-44), d) older adults (ages 45-64) and e) geriatric patients (age ≥65). While respiratory complaints were the most common reason that EMS was summoned for patients younger than 20, chest pain was the predominant reason for 911 calls in adult patients.

Discussion
By reviewing EMS data for 911 calls from family medicine and urgent care practices, we have demonstrated that emergencies prompting these calls occurred in patients of all age groups with a wide range of medical conditions. However, some specific trends do emerge from our data:

- First, older patients were most likely to require EMS services. This appears to be consistent with the NAMCS report in 2001, which noted that the number of visits to office-based physicians increases with patient age.9
- The emergencies in this older population of patients appear more likely to be cardiopulmonary in origin.
- Younger patients in the primary care office setting who require emergency services are more likely to have respiratory complaints, which is also consistent with previous studies.3

These data suggest that family medicine and urgent care physicians need to be prepared to deliver care for a diverse group of patients with a wide variety of emergency conditions.

Perhaps the most dramatic of all emergencies that can occur in the office is the patient who sustains a cardiac arrest. In our series, seven cases of cardiac arrest occurred in five different practices (two urgent care, three family medicine) and accounted for 1% of all calls to EMS. The youngest victim was 9 months of age; the oldest was 80 years of age. In a review of 142 cardiac arrests in medical and dental practices in King County, WA, family medicine and urgent care practices were just as likely to have a cardiac arrest occur in the office as were cardiology and internal medicine practices. Only dialysis centers were more likely than these office settings to have a patient sustain a cardiac arrest.1

Data from the NAMCS report note that between 1992 and 2001, office visits became more complex, involving older patients with more diagnoses per visit and more multiple medications to manage.5 If this trend of older, more complex and ill patients making office visits continues, it is possible that the need for EMS and emergency care in the family medicine and urgent care office may increase, as well.

Strengths and Limitations
Previous surveys of pediatric office practices attempted to identify the frequency of emergencies in the office, but such studies were plagued by recall bias and what defines an emergency.2,8 By identifying a clear and reproducible definition of an emergency (i.e., a call to 911 from the medical office), we have been able to avoid this dilemma.
The locations of the office practices used in our study represented a mix of urban, suburban, and rural practice locations and varied in their distances to the nearest acute care hospital (Table 5). The practice types also ranged from solo practitioner to large group practices. All were private practices, including one family medicine residency clinic site. The breadth of practice locations, types of practices, and large sample size represent the broad range of family medicine and urgent care practices in which medical emergencies may be encountered. However, regional trends in practice patterns—in particular the limited amount of obstetrics performed by family physicians in northeastern New York state—may limit the “generalizability” of our results.

In this study, only three of 16 family medicine and none of the urgent care offices cared for obstetric patients. Therefore, the low frequency of obstetrical emergencies in our study may be underrepresented when compared with other regions of the country.

All of the practices included in this study were contacted in hopes of obtaining the number of patients evaluated at each facility during the study period, so that a rate of 911 calls from the office could be calculated. However, either due to unwillingness or lack of available data, a number of offices could not provide the requested data, thus limiting a calculation of rates for these occurrences. Since a demographic base of all patient visits was not available for the practices studied, only limited, indirect comparison with the NAMCS data was possible.

Misclassification of the chief complaint might be possible if the EMS dispatcher incorrectly documented the chief complaint in the computer record or the EMS provider incorrectly documented the chief complaint on the documentation form in the two smaller communities without computerized EMS documentation. Since we were unable to obtain either audio recordings of the 911 calls or the subsequent admission and discharge diagnosis in this study group, misclassification of some of our cases is possible. However, we believe that this lack of validation does not diminish the conclusions of this large descriptive study since, in most cases, the chief complaint was unambiguous and in cases where multiple complaints were present, all complaints were recorded.

Finally, our study did not address the question of preparedness for emergencies in the office setting. One survey of family physician preparedness for pediatric emergencies conducted in North Carolina suggested that family physicians were less likely to have pediatric resuscitation equipment or Pediatric Advanced
Life Support (PALS) training, when compared with pediatricians. No other studies of preparedness for emergencies of any kind in the primary care office setting could be identified. We believe this question would be worthy of future evaluation.

**Conclusion**

We have demonstrated that 911 calls from family medicine and urgent care practices in northeastern New York were placed for patients of all ages and a wide variety of medical conditions. Older patients were most likely to require EMS services in the office setting, with chest pain the most common chief complaint. In pediatric patients, respiratory emergencies were the most common reason for a 911 call from the office setting.

### REFERENCES


### Table 5. Types and Locations of Practices in the Study

<table>
<thead>
<tr>
<th>Practice*</th>
<th>No. of EMS calls</th>
<th>Miles to hospital†</th>
<th>Location‡</th>
<th>Practice size§</th>
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<td>6</td>
<td>Suburban</td>
<td>Solo</td>
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</table>

*FP = Family practice; UC = Urgent care; †Rounded to closest mile, as calculated by Mapquest; ‡Per 2004 U.S. census population estimates; §Solo=1 physician with possible midlevel provider; medium=2-5 physicians; large=>5 physicians
ABSTRACTS IN URGENT CARE

On Stone Passage, Wait-and-See Prescriptions, Foreign Bodies, and Wireless Prescribing

NAHUM KOVALSKI, BSC, MDCM

Each month, Dr. Nahum Kovalski will review 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.

Medical Therapy to Facilitate Urinary Stone Passage: A Meta-analysis
URL: http://www.thelancet.com/journals/lancet/article/PIIS0140673606694749/abstract
Key point: Medical therapy is an option for facilitation of urinary-stone passage.

Medical therapies to ease urinary-stone passage have been reported, but are not generally used. If effective, such therapies would increase the options for treatment of urinary stones.

The authors searched MEDLINE, Pre-MEDLINE, CINAHL, and EMBASE, as well as scientific meeting abstracts, up to July 2005. All randomized controlled trials in which calcium-channel blockers or α-blockers were used to treat ureteral stones were eligible for inclusion in the analysis. Data from nine trials (N=693) were pooled. The main outcome was the proportion of patients who passed stones.

Patients given calcium-channel blockers or α-blockers had a 65% (absolute risk reduction=0.31) greater likelihood of stone passage than those not given such treatment. The pooled risk ratio for α-blockers was 1.54 and for calcium-channel blockers with steroids 1.90. The proportion of heterogeneity not explained by chance alone was 28%. The number needed to treat was 4.

Comment: The authors note that although a high-quality randomized trial is necessary to confirm its efficacy, these findings suggest that medical therapy is an option for facilitation of urinary-stone passage for patients amenable to conservative management, potentially obviating the need for surgery.

Wait-and-See Prescription (WASP) for the Treatment of Acute Otitis Media: A Randomized Controlled Trial
Citation: Spiro DM, Tay KY, Arnold DH, et al. JAMA. 2006;296:1235-1241.
Key point: The WASP approach substantially reduced unnecessary use of antibiotics in children with acute otitis media (AOM) seen in an emergency department.

AOM is the most common diagnosis for which antibiotics are prescribed for children. Previous trials that have evaluated a “wait-and-see prescription” (WASP) for antibiotics, which parents are asked not to fill unless the child either is not better or is worse in 48 hours, have excluded children with severe AOM. None of these trials were conducted in an emergency department.

This was a randomized controlled trial, from July 12, 2004 to
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July 11, 2005, involving children with AOM aged 6 months to 12 years seen in an ER. These children were randomly assigned to receive either a WASP or a standard prescription (SP). Overall, 283 patients were randomized either to the WASP group (n=138) or the SP group (n=145).

Substantially more parents in the WASP group did not fill the antibiotic prescription (62% vs. 13%; P<.001). There was no statistically significant difference between the groups in the frequency of subsequent fever, otalgia, or unscheduled visits for medical care.

Within the WASP group, both fever (relative risk [RR], 2.95; P<.001) and otalgia (RR, 1.62; P<.001) were associated with filling the prescription.

Foreign Body Removal From the External Auditory Canal in a Pediatric Emergency Department

Citation: Marin JR, Trainor JL. Pediatr Emerg Care. 2006; 22:630-634.


Key point: Referral to otolaryngology should be considered if more than one attempt or instrument is needed for removal of a foreign body in the ear canal.

Physicians in the authors’ pediatric emergency department successfully removed 204 (80%) of 254 foreign bodies. In 30 cases (12%), there was a complication. Multiple attempts at removal were associated with failure (relative risk [RR], 6.0) and complications (RR, 3.1). The use of multiple instruments was also associated with failure (RR, 5.4) and complications (RR, 4.0).

Of the 244 patients in whom emergency department attempts at removal were made, 26 were successfully removed in otolaryngology clinic, and 14 were removed in the operating room.

Foreign bodies present in the canal for more than 24 hours were not at higher risk of failed removal or complications. Patients younger than 4 years also were not at increased risk of having failed removal or complications.

Comment: In medicine, proper resource management means filtering out cases that can be handled by the more immediate and readily available ER/urgent care doctor, before referral onto specialty care. Eighty percent of these FBs can be successfully removed by the first-line doctor. And if the first attempt failed, then this group—only 20% of the original—can be referred on. For those FBs removed in the ENT clinic, one could ask what special equipment made this possible (e.g., suction, finer instruments, magnification). One could then look into duplicating some of these tools (like the suction) in other settings to further increase first-line success.

Wireless Handheld Computers and Voluntary Utilization of Computerized Prescribing Systems in the Emergency Department


URL: http://www.imedi.org/docs/Azyxxi/Papers/PDA%20prescribing%20-%20for%20pdf.pdf

Key point: Physicians are amenable to using wireless handheld computers for prescribing.

Illegible or invalid handwritten prescriptions can result in avoidable medical errors. Computer-based prescribing can mitigate the problem.

An observational study was performed to examine the effect of wireless handheld computers (handhelds) on voluntary utilization of computerized prescribing within an emergency department. Handhelds with prescription-writing software were provided to physicians and the numbers of hand-written and computer-generated prescriptions were compared before and after the introduction of the handhelds.

The resulting increase in computer-based prescribing was statistically significant and was observed largely among physicians who already used desktop computers for prescribing.

The study concluded that handhelds increased voluntary utilization of computerized prescribing, but that the physicians most likely to use handhelds were those who already used desktop-based prescribing.

Comment: The approach that this group adopted is an interesting and successful one. Rather than force the staff to move, altogether, over to the new digital prescribing system, the doctors were allowed to choose which system they preferred. As the years pass, and more and more doctors are young enough to have played with video games as a child, e-prescribing (as well as all forms of digital medical records) will become the de-facto standard. The key to the success of any digital medical system is improved physician productivity which should translate into greater reimbursements, or at least, reduced medicolegal risk.
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 e-mail the relevant materials and presenting information to editor@jucm.com.

CLA ECN 1: CASE 1

A 2 1/2-year-old child presents with a three-day history of cough but no fever. Upon examination, you find:
- Oxygen percent saturation 95%
- Resting respiration 31/min
- Pulse 145/min
- Decreased air entry over the left chest

View Figure 1, take these findings into account, and consider what your next steps would be. Resolution of the case is described on the next page.
The reading of the chest x-ray was “suspected foreign body in the left main bronchus.” This reading was based on overinflation of the left lung with deviation of the trachea, increased lucency of the left lung area, and flattening of the left diaphragm. The increased lucency makes the ribs and scapula more prominent on the left.

The child was sent to the ER and was bronchoscoped. No foreign body was found, although there was inflammation along the main bronchus. The initial impression of the ER physicians was that a foreign body had been present but since been expelled. The child is still under observation.

Acknowledgment: Case managed by Drs. Scott Fields (radiologist) and Aryeh Poms (primary physician).
A 53-year-old female presents after experiencing a fall with a blow to the knee several hours earlier. Upon examination, you find:

- No fluid in the knee
- The knee is stable
- Patient is able to put weight on the affected knee
- Mildly decreased range of motion due to generalized pain in the area (though not over the patella)

View Figure 1, take these findings into account, and consider what your next steps would be. Resolution of the case is described on the next page.
The diagnosis of the orthopedist who saw this case was bipartate patella. However, the radiologist suspected that this was in fact a fracture.

Nonetheless, the orthopedist felt that it was not a fracture because (a) the pain was not over the patella and (b) comparison with old films (which the radiologist had not seen) showed that nothing had changed on the new films.

This is a perfect example of the need to have as much relevant clinical information as possible, and the importance of accessing old films when available. Without this information, neither the orthopedist nor the radiologist could have given an absolute final diagnosis. This case also reminds us of the need to provide all of the clinical information to the radiologist in all cases.

Interestingly, both the orthopedist and the radiologist noted that the patient should have a CT to confirm the status of the patella.

Acknowledgment: Case managed by Drs. Rafold Livshin (orthopedist), Uri Frankl (orthopedist), and Scott Fields (radiologist).
In the December issue of JUCM, Dr. Shufeldt introduced a discussion on how to not be named in a malpractice suit by suggesting that providing excellent customer service, never saying “no” to a patient, and thorough documentation of the pertinent positives and negatives are viable techniques to reduce your malpractice exposure. Here, he continues the discussion with other precautions you can take.

Failure to make an appropriate referral is a reason commonly cited when providers are sued. This broad category includes failure to suggest hospitalization, failure to call for a consult, and failure to prescribe a specific plan or treatment. For example, if a patient admits to being a smoker and you diagnose bronchitis or some other respiratory condition exacerbated by smoking, your chart or aftercare instructions would be incomplete if you did not discuss—and document—smoking cessation as part of the treatment plan.

This may sound painfully obvious, but I assure you that cases have been lost for even more trivial reasons than that. You don’t want to be the defendant when the patient is on the witness stand testifying that, “If the physician had only told me to lose weight, quit shooting heroin, quit smoking meth, wear a helmet, etc.) I would certainly have followed his advice and altered my behavior. I had no idea that was dangerous!”

If you are treating a patient whose symptoms, exam, and lab findings are not adding up, or if your gut is telling you something is wrong with the patient despite your objective findings, trust your gut! I cannot tell you how many horrendomas I have found purely through dumb luck and listening to my gut.

The “out” we have in urgent care medicine is simply to tell the patient that their symptoms, exam, findings, etc. warrant further evaluation in the hospital. Document your discussion, copy your notes for the patient to give to the emergency physician, and send them off to the ED.

**Err on the Side of Caution**

Since we do not typically have an ongoing relationship with the patient or the patient’s family, it is much better to err on the side of caution. That includes treating the patient even if only “soft” evidence is available.

For example, I would manage patients who present with a sore throat and have a negative rapid strep and no evidence of mono by writing scripts for pain medicine and an appropriate antibiotic with the admonition not to fill the antibiotic prescription unless the symptoms worsen or are no better after two more days.

Before the evidence-based crowd calls for my head on a platter, consider this: Rapid streps are notoriously unreliable, patients with a viral sore throat will usually be better in two days, and very often patients who do not “get a prescription like my regular doctor gives me” simply go to their PCP to get the script you refused to give them and incur the cost of two visits. Again, I know this is not evidence based; however, it is practicality based and much more patient friendly.

You may have heard the statement, “every patient is a potential plaintiff.” Unfortunately, this blatantly pessimistic statement is true. As providers, we must evaluate every patient as if we will be sitting across the mediator’s table—or worse, the courtroom—from them.

In emergency medicine, we are obligated to take all comers; we do not have the luxury of dismissing patients from our practice. This is not true in urgent care medicine, however. If you are faced with a patient who is unruly or rude or repeatedly non-compliant or abusive, you do not need to continue to provide care for them. In fact, if it is their first visit and they are abusive in the waiting room, take this an omen that you will ultimately not want them in your practice and ask them to seek care elsewhere.

John Shufeldt is chief executive officer of NextCare, Inc. and sits on the Editorial Board of JUCM The Journal of Urgent Care Medicine.
Once you start treatment, however, you are obligated to complete it for the particular episode of illness. If it is a recurrent patient, send a certified letter advising them that they should seek care elsewhere and provide a list of other urgent care centers. Also, tell them you will continue to see them over the next 30 days but after that you will no longer provide any services. A certified letter in the urgent care environment is probably overly cautious, but it covers the bases for a claim of patient abandonment.

Beware the Minimizer!

Minimizers are patients who are often “forced” to seek care by loved ones who may have been clued in to some change in behavior or condition that has them concerned. One common chief complaint that I have heard countless times when asking males why they are here today is, “I don’t know; my wife made me come in.”

These patients should set off alarms. This is the 55-year-old, out-of-shape guy who complains of intermittent, reproducible shoulder pain aggravated by the “honey dos” that his significant other has him performing. He’s the same guy who walks you down the path of a repetitive trauma condition or muscle strain and is discharged after a negative shoulder x-ray and no EKG, then drops dead of a myocardial infarction.

When you sense you have a patient who is “dismissive” of his own complaints, be aware that the non-issues may be a harbinger for serious illness.

You may have also heard this before: “I would like to have that test, but I just can’t afford it,” or, “Can’t you just treat me, I am sure I am fine.” Basing prescribed treatment on the patient’s financial status is wrought with danger. Clearly, some patients cannot afford the “correct way” to work up an issue. However, this should not stop you from ordering the test, medications, etc., and allowing the patient to decide whether or not to spend the money.

This is the basis of informed consent: giving patients enough information to decide for themselves after weighing everything. Remember, “cost effectiveness” does not carry weight in a standard-of-care determination. The take-home point here is to practice good medicine, foster informed consent, and document everything.

Ultimately, not being named in a malpractice suit requires a good deal of luck. However, avoiding issues commonly cited as reasons that providers are named in suits will also lower your chances for ending up at the defendant’s table.

In summary, being kind and respectful to patients and families, thoroughly documenting the treatment and the plan, facilitating informed consent, identifying the patient who is non-compliant, abusive or minimizing, and not letting patient’s finances dictate your prescribed treatment will significantly reduce your risk of being named in a malpractice suit.

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**Call for Articles**

The *Journal of Urgent Care Medicine* (*JUCM*), the Official Publication of the Urgent Care Association of America, is looking for a few good authors.

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

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

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Lee Resnick, MD at editor@jucm.com.

He will be happy to discuss it with you.
C O D I N G  Q & A

Coding Conundrum: E/M with a Procedure

DAVID STERN, MD, CPC

The urgent care practitioner may not live by coding alone, but proper reimbursement depends on it. To that end, Dr. David Stern, a certified coder who is in great demand as a speaker and consultant on coding in urgent care, will offer answers to commonly asked questions in every issue of JUCM.

In this issue: proper coding for evaluation and management (E/M) in addition to other procedures.

Q. We always get denials for the E/M code in addition to a procedure. Are we doing something wrong?

A. Denials for payment for an E/M in addition to a procedure may stem from several sources:

- **Missing modifier**
  If you perform a procedure with a 0- or 10-day global period and you perform and document a separate E/M on the same day, always attach modifier -25 to the E/M to reduce denials and costs of rebilling. Use modifier -57 for an E/M performed on the same day as a procedure with a 90-day global period.

- **Payor policy**
  Some payors routinely deny payment for an E/M in addition to a certain (rarely all) procedures.

- **Bundling issues**
  Generally, procedure codes include a basic level of evaluation of management within the procedure code. In the urgent care setting, however, bundling the E/M into the procedure code is frequently not appropriate.

- **Lack of supporting documentation**
  Some payors automatically deny an E/M in addition to a procedure, or at least in addition to a certain procedure. For example, some payors deny payment for an E/M when billed in a claim along with a code for ear wax removal. Even in these cases, however, payment might be obtained by submitting proper documentation.

Q. What urgent care procedures require modifier -25?

A. In general, all procedures with a 10-day global period (and many others with a 0-day global period) should have modifier -25 attached to the E/M code.

Q. When is modifier -25 used?

A. Per the AMA definition, modifier -25 should be used when a “significant, separately identifiable E/M service above and beyond the other service provided or beyond the usual preoperative and postoperative care associated with the procedure that was performed” is required. The interpretation of this rule is sometimes difficult and there are a few gray areas where not all coders or payors agree. For example:

- **Patients who are new to a practice** The initial E/M (99201-99205) for a new patient who also has a minor procedure (0- to 10-day global period) performed on the same day should not require the -25 modifier on the E/M code. This makes sense, as the patient is not known to the provider and all of the baseline history, medications and basic health status must be determined prior to doing the “usual preoperative care.”

- **New problems that require significant evaluation beyond the procedure** For example, a patient may present with knee pain. After evaluation of the knee, the physician determines that the problem may be gout or infectious arthritis, and that it is necessary to aspirate the joint and send the fluid to the lab for analysis to help confirm the diagnosis. Code with the E/M with modifier (for example, 99213-25) and 20610 for the knee joint aspiration. Thus, a new problem that requires more than a cursory review also, generally, qualifies for an E/M with modifier -25.

David Stern is a partner in Physicians Immediate Care, with nine urgent care centers in Illinois and Oklahoma, and chief executive officer of Practice Velocity (www.practicevelocity.com), a provider of charting, coding and billing software for urgent care. He may be contacted at dstern@practicevelocity.com.
### Coding Q & A

Patients undergoing a procedure that is made more complicated because of an underlying medical problem should have that problem evaluated and managed appropriately. Take, for example, a patient who presents with an abcess and who also suffers from AIDS, diabetes, valvular heart disease, or elevated blood pressure. In this case, the physician should document evaluation and management of both the problem that is addressed by the procedure and the E/M of the complicating problem. An E/M with modifier -25 is always appropriate in addition to the code for the procedure.

"Established patients" with a second medical problem that requires attention An E/M is always appropriate for patients receiving evaluation and management services for diagnoses in addition to the problem necessitating the procedure. For example, a patient may present with a laceration, but in the course of evaluation and management the physician determines that the patient has also been suffering from chronic diarrhea. The physician begins the work-up by ordering collection of a stool specimen for culture and microscopic examination for ova and parasites. The laceration code and the E/M code is used.

"Established patients" seen in the urgent care setting A typical urgent care center is quite different from a typical physician office. In the urgent care center, very few patients are truly established with the provider who is providing the services. Essentially, these are new patients who truly need a thorough history and physical prior to the initiation of the usual preoperative care. Thus, in the urgent care center a full history and physical are almost always required to evaluate the past medical history, medications, and current symptoms prior to initiating the usual preoperative care that would be provided to a patient who was truly established and, thus, well known to the provider.

It is one thing for Dr. Welby to walk in the room and say, “Oh, Johnny, so you cut your finger again. You need to be more careful with your whittling knife. Don’t worry, we’ll sew that up in a jiffy. Since you don’t have any other problems except for that heart murmur, you should do great.”

It is another matter entirely for Dr. Urgentowitz to see the same patient, and inquire about diabetes, history of infections, the relevance of the heart murmur, and the patient’s experience with previous injuries. Then the urgent care doctor examines the patient’s skin, eyes, heart, lungs, and peripheral vasculature to evaluate the status of any known conditions and to see if there are any additional underlying or complicating medical conditions.

Generally, a separate E/M is appropriate for patients seen in the urgent care center. Of course, if the urgent care physician also functions as the primary care provider for the patient, the patient is truly established with the practice and an additional E/M is often not appropriate.

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
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<tr>
<td>Must I have a separate diagnosis to code modifier -25?</td>
<td>One myth that seems to have a life of its own is that the patient must have a “significantly separate identifiable” problem that is managed on this visit. But the AMA definition of modifier -25 clearly states: &quot;The E/M service may be prompted by the symptom or condition for which the procedure and/or service was provided. As such, different diagnoses are not required for reporting of the E/M services on the same date.” The problem and confusion arises, however, when overzealous payors (in direct contradiction of AMA guidelines) require physicians to treat a second condition before they will consider payment for an E/M with modifier -25. It is the E/M note, not a second presenting problem, which must be “significant and separately identifiable.” Nonetheless, several large payors continue to apply the tightfisted requirement that the physician must supply both documentation of a second diagnosis and medical records supporting separate E/M services for that second diagnosis.</td>
</tr>
<tr>
<td>Will attaching modifier -25 to an E/M where the modifier was not required trigger a denial?</td>
<td>No, payors almost never deny payment for attaching modifier -25 to an E/M code where the modifier was not required. Be careful to use modifier -25 only when a procedure is performed, as overuse of the modifier may trigger a payor audit.</td>
</tr>
<tr>
<td>I was audited and the carrier denied payment because of inadequate documentation. Do I simply need a longer visit note?</td>
<td>It is not the length, but the content of the visit record that is important. In order to support both an E/M code and a procedure code, the patient record must contain documentation of the level of evaluation and management AND a significant separately identifiable procedure note. It is best to not include the procedure note within the evaluation and management note, as some auditors will deny the code because the procedure note was not “separately identifiable” from the evaluation and management documented in the patient record. Some coders go so far as to recommend a separate page, template, or dictation for each E/M and each procedure note.</td>
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</table>

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BLS/ACLS/PALS, suture experience preferred. We are a large, Urgent Care region seeks physicians for both BC EM physicians. EPMG offers paid family medical benefits, incentive bonuses, flexible scheduling, paid malpractice, and more.

Please contact Kim Senda
800-466-3764 x338 or ksenda@epmgpc.com

Portsmouth/Wheelersburg, Ohio
BC/BP, PC, or IM physicians needed for 22,000-25,000 visit freestanding urgent cares. No nights! Back-up provided by Southern Ohio Medical Center’s main campus. EPMG offers paid family medical benefits, incentive bonuses, flexible scheduling, paid malpractice, and more.

Please contact Kim Senda
800-466-3764 x338 or ksenda@epmgpc.com

Hobart, Indiana
EM opportunities at 25,000 visit ED located 35 miles south of Chicago and 15 miles northwest of Valparaiso. BC/BP PC with EM experience. Shift is 11:00am-11:00pm and provides double coverage for BC EM physicians. EPMG offers paid family medical benefits, incentive bonuses, flexible scheduling, paid malpractice, and more.

Please contact Kim Senda
800-466-3764 x338 or ksenda@epmgpc.com

FREE OCEAN CITY CONDO PHYSICIAN & PA & NP
Full-time/part-time or summer position with salary, bonuses, malpractice, flexible schedule.

NO CALL and NO HMO Partnership opportunity. Be a part of our team at our friendly multi-site urgent care centers. Luxury beach condo with pool, tennis and more.

75TH ST MEDICAL
7408 Coastal Hwy
Ocean City, MD 21842
(410) 524-0675 • Fax (410) 524-0066
WWW.75THSTMEDICAL.COM

Excellent Internal Medicine Family Practice Opportunities

UGLY CARE CLINIC
Southern California’s leading physician-owned multi-specialty medical group has opportunities for full-time Internal Medicine/Family Practice physicians in our Long Beach and Los Angeles regions. Candidates must be Board certified, have a current California medical license, DEA current, BLS/ACLS/PALS, suture experience preferred. We are a large, dynamic and well-established group and offer a balanced professional and personal lifestyle, as well as excellent compensation with Partnership Track and benefits.

We have immediate openings for per diem and full-time physicians for a variety of shifts. Our busy Urgent Care Clinic treats patients for anything from a common office visit to an emergency room visit. Our patient population includes children, adults and seniors. We will consider 3rd year/senior residents with letters from residency program chief resident or director approving moonlighting.

HealthCare Partners
Mail or email CV to:
HealthCare Partners, Clinician Recruitment
19181 So. Vermont Ave, Ste 300, Torrance, CA 90502
Email: sdeeming@healthcarepartners.com
Apply on line at
http://www.healthcarepartners.com/careers/careers
Clinician/Physician Opportunities

EMERGENCY MEDICINE/URGENT CARE WISCONSIN
Marshfield Clinic is directed by 700+ physicians practicing in over 80 specialties at 40 locations in central, northern and western Wisconsin. We are seeking BC/BP Family Practice physicians at the following locations:

• Ladysmith - Urgent Care
• Marshfield - Urgent Care
• Park Falls - Emergency Dept/Urgent Care
• Rice Lake - Emergency Dept/Urgent Care

We offer a competitive salary and a comprehensive benefit package including: malpractice, health, life, disability, and dental insurance; generous employer contributed retirement and 401(k) plans; $5,500 education allowance with 10 days of CME time; four weeks vacation 1st year; up to $10,000 relocation allowance; and much more.

Please contact: Sandy Heeg,
Physician Recruitment, Marshfield Clinic
1000 N Oak Ave., Marshfield, WI 54449
Phone: 800-782-8581, ext. 19781
Fax: (715) 221-9779
E-mail: heeg.sandra@marshfieldclinic.org
Website: www.marshfieldclinic.org/recruit

Marshfield Clinic is an Affirmative Action/Equal Opportunity employer that values diversity. Minorities, females, individuals with disabilities and veterans are encouraged to apply.

Sorry, not a health professional shortage area.
Career Opportunities

Northern California Urgent Care Opportunities

Sutter Medical Group (SMG) is seeking Family Practice physicians to staff an urgent care clinic located on the campus of Sutter Roseville Medical Center. SMG is a large multi-specialty group of over 200 physicians.

- Full-time and part-time opportunities are available.
- Clinic hours of operation:
  - Mon.-Fri. 6 p.m. - 10 p.m.
  - Sat.-Sun. 8 a.m. - 8 p.m.

Roseville is located 16 miles northeast of Sacramento. Roseville has excellent schools, and is a family oriented community. Roseville is centrally located only a 1-1/2 hours drive from mountains of Lake Tahoe, and the bay of San Francisco.

Contact: Susan Wadhwani, Sutter Health, SSR
800-650-0625
916-454-6645 fax
devopers@sutterhealth.org
www.sutterhealth.org

Practice for Sale

MARYLAND - Urgent Care/Occupational Medicine

Profitable, busy free standing Urgent Care/Occupational Medicine/Forensic drug & alcohol testing business Eastern Shore of Maryland. Operating since 1995. Ideal for EP/FP wishing to reduce hours and stress. Owner willing to work with purchaser both financially and professionally during transition. Serious inquiries only.

Respond: JJB, FLP, 30734 Foxchase Dr., Salisbury, MD 21804.
E-mail: oneilburns@msn.com

With a circulation of 10,000 urgent care subscribers, there are plenty of reasons why your company should be a part of The Journal of Urgent Care Medicine’s 11 monthly issues.

Please visit our website www.rja-ads.com/jucm for classified advertising rates or if interested in a price quote, please fax or email your advertisement to my attention.

Next available issue is March, with a closing date of February 5th.

Contact Trish O’Brien
(800) 237-9851 • Fax (727) 445-9380
jumc@rja-ads.com

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jumc@rja-ads.com

Naples, Florida
A progressive family practice, occupational medicine and urgent care facility is expanding! Competitive salary and excellent opportunity for growth for Board Certified MD. Candidates should have a Florida License and enjoy fast paced work environment.

Contact: lmartell@advancedmedicalcenter.com

COASTAL NORTH CAROLINA
Board-certified physician needed for urgent care/family medicine office in Jacksonville, North Carolina.

Contact: Bob Kastner, M.D.
Phone: (910) 392-2424
E-mail: kastner@bellsouth.net
No J-1 Visas

ARKANSAS
Urgent Care opportunity offering hourly compensation with incentive bonus, partnership track, paid malpractice and tail insurance. Located adjacent to emergency department of regional referral hospital. For more information contact: Lisa Morgan at lisa@eddocs.com • (888) 800-8237

GEORGIA
UGRNT DRAR CARE DOCTOR NEEDED
Three 12’s a week and one Sunday a month. Monday-Saturday 8-8; Sunday 9-6. On-site CT Digital x-ray, lab, etc. No call, hospital or nights. No egos! Great pay!! Call for information. (770) 527-8183.

MARYLAND - Urgent Care/Occupational Medicine

Profitable, busy free standing Urgent Care/Occupational Medicine/Forensic drug & alcohol testing business Eastern Shore of Maryland. Operating since 1995. Ideal for EP/FP wishing to reduce hours and stress. Owner willing to work with purchaser both financially and professionally during transition. Serious inquiries only.

Respond: JJB, FLP, 30734 Foxchase Dr., Salisbury, MD 21804.
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"Keep your ear to the customer" is a central tenet of effective marketing. Awareness of how your services are used and valued can be especially important in a field like occupational medicine, where the people you treat are often not the ones who contract for those services.

There are many ways to keep your ear to the customer, and there are many customer subgroups. "Customers" might include patients, employers, carriers/payors, or specialists. Keeping close to these constituents invariably involves the use of multiple modalities such as e-mails, periodic phone calls, patient satisfaction instruments, and questionnaires.

Why Assess?
Urgent care clinic operators often rely on intuition or anecdotal information to assess how their clinic is viewed in their community. Invariably, this information lags behind reality. You need to be proactive in seeking out real customer feedback. A simple questionnaire survey administered to a sample of patients and/or client companies can:
- tell you how well you are doing in a variety of service areas and turn up suggestions for improved performance.
- generate accolades that can later be used in marketing material and to enhance staff morale.
- provide you with cross-selling opportunities for other services.
- help you identify (and rectify) areas in which your clinic is slipping and, conversely, provide objective validation of how a clinic has improved.

How to Assess
While your survey should reflect your particular needs, following a few general rules may help ensure the effort is worth your while:
1. Do the survey annually.
2. Keep it simple and short—one two-sided sheet of paper.
3. Allow participants to complete the questionnaire via hand copy (mail) or electronically via e-mail.
4. Send out a second questionnaire (and/or e-mail blast) to non-respondents after a few weeks.
5. Offer the chance to win a prize on the back end. It can be something simple, such as dinner for two at a local restaurant.
6. E-mail respondents with a “thank you” and a summary of selected findings.

What to Assess
Ask participants:
- what they think of your clinic, and what you can do better
- if there are other valuable services you could offer
- if one or more of your staff warrant special praise
- about multiple aspects of your clinic using a scale of 1 (poor) to 5 (excellent)
- about their receptiveness to and the viability of any changes you’ve made in the clinic during the previous year; for example, a reconfigured waiting area
- about any other pressing issue of the moment, e.g., if and where to open another clinic.

More Than Information
The value of a questionnaire survey goes beyond data. Constituents appreciate being asked their opinion. It doesn’t hurt to make that point in your cover letter and/or e-mail overview: “Because you are a valued Med Center client, we are deeply interested in your thoughts about and suggestions for our clinic....” Marketing is about calling attention to your clinic and using multiple hits to remind clients, partial clients, and prospects that your clinic is alive and well and operating in a professional manner.

Conducting an annual questionnaire survey is not particularly time-consuming or expensive. It is an excellent way to stay in touch with your best customers or patients, learn more about the community’s perception of your clinic, maintain an up-to-date information base, and remain visible.

If you would like to receive a sample survey questionnaire to see how these suggestions are carried out by, please e-mail Janelle Schueler at jschueler@naohp.com.
DEVELOPING DATA

UCOA’s Survey Committee drew two important conclusions from its first industry-wide survey: urgent care is a growing industry nationwide, and those within the industry are hungry for benchmarking data. In each issue of JUCM, Developing Data will seek to fulfill that need.

In this issue, who owns, who leases, and where are they located?

TYPE OF STRUCTURES HOUSING URGENT CARE CLINICS

More than half (53%) of the survey participants own the buildings in which their practice is located; 47% lease. The average business consists of 2.66 centers.

Areas covered in the initial UCAOA industry survey included urgent care structures and organization, services offered, management of facilities and operations, patients and staffing, and financial data. UCAOA members who have ideas for future surveys should e-mail J. Dale Key, UCAOA Survey Committee chair, at dkey@medachealth.com.

Next month in Developing Data:

One of the benefits of urgent care, from a patient’s perspective, is the time savings and more convenient access to medical care compared with a visit to the ER or family practice. But just what are “average” hours (and days) of operation for an urgent care clinic?
and as with other quinolones, disturbances of blood glucose, including symptomatic hyper- and hypoglycemia, have been reported in patients treated concomitantly with quinolones and other antihyperglycemic agents. Patients should be advised about the symptoms of altered blood glucose levels and be instructed to monitor their blood glucose levels regularly. If hypoglycemia occurs, patients should discontinue levofloxacin and notify their physician immediately.

ADVERSE REACTIONS.

The following is a brief summary only. Before prescribing, see complete Prescribing Information for a detailed description of all adverse reactions.

ADVERSE REACTIONS.

Data from clinical studies of LEVAQUIN in adult patients with respiratory tract infections, pyelonephritis, upper urinary tract infections, and prostatitis revealed an overall incidence of adverse events reported by patients taking levofloxacin (750 mg once daily) of 15.2% versus 11.8% for placebo. In these studies, the most commonly reported adverse events were: nausea 6.8%, headache 5.8%, diarrhea 5.4%, insomnia 4.6%, constipation 4.3%, dizziness 3.9%, and pharyngitis 3.7%. In multiple-dose clinical trials, the proportions of adverse events noted were similar between patients receiving levofloxacin and patients receiving placebo.

The following is a list of adverse reactions attributed to treatment with LEVAQUIN (levofloxacin) that were reported by at least 1% of adult patients in clinical trials involving 1,200 patients. These reactions were similar in incidence in patients receiving LEVAQUIN 500 mg and 750 mg once daily. The reactions are listed by body system and ordered from most frequent to least frequent within each body system:

• Central and Peripheral Nervous System:
  - Headache
  - Dizziness
  - Insomnia
  - Somnolence
  - Drowsiness
  - Lightheadedness
  - Tremor
  - Nervousness

• Cardiovascular System:
  - Palpitations

• Gastrointestinal System:
  - Nausea
  - Diarrhea
  - Abdominal pain

• Respiratory System:
  - Dyspnea

• Skin:
  - Pruritus

• Miscellaneous:
  - Anaphylaxis

The pharmacokinetic properties of LEVAQUIN in young adults and elderly adults are not fully established. Available studies indicate that the extent of disposition of LEVAQUIN, as determined by the ratio of area under the curve (AUC) to apparent elimination half-life (t1/2), was four- to fivefold higher in elderly subjects (aged 70 to 89 years) when compared to young adults (aged 19 to 40 years). However, based on the pharmacokinetic data, the AUCs were comparable in these age groups when a dose of 500 mg of LEVAQUIN was administered orally to young adults and elderly adults. Therefore, the dosing regimen for LEVAQUIN in elderly adults was established at 500 mg once daily. The dosing regimen for LEVAQUIN in young adults was established at 750 mg once daily. These dosages are based on the constancy of the pharmacokinetic profile with increasing age. The safety and efficacy of LEVAQUIN in pediatric patients have not been established. LEVAQUIN was administered to 109 pediatric patients (aged 6 months to 15 years) in clinical studies. In studies of children aged 6 months to 12 years, the most frequently reported adverse events were nausea, vomiting, headache, abdominal pain, diarrhea, and pharyngitis.

Information for Patients and Adverse Reactions

Serious and potentially fatal side effects are sometimes observed with quinolone therapy, including photosensitivity reactions, seizures, and toxicity involving the nervous, gastrointestinal, genitourinary, metabolic, respiratory, cardiovascular, musculoskeletal, or skin systems. These reactions may occur with all quinolones and are likely to be drug-related. Some patients may experience more than one of these side effects, with or without warning signs, and they may appear any time during treatment.

Serious and potentially fatal side effects that have been reported with quinolones include: seizures, photosensitivity reactions, Stevens-Johnson syndrome, toxic epidermal necrolysis, peripheral neuropathy, and tendon rupture. Seizures have been reported with quinolones such as levofloxacin. These seizures have occurred in patients with and without known or suspected CNS disorders. The possibility of exacerbation or triggering of a seizure in patients with CNS disorders, such as epilepsy, should be considered prior to using LEVAQUIN. Because seizures can occur during or after quinolone therapy, patients should be instructed to discontinue LEVAQUIN and consult their healthcare provider if seizures occur. Photosensitivity reactions have been reported with LEVAQUIN. Photosensitivity reactions are more likely to occur in patients who have a history of photosensitivity reactions. Photosensitivity reactions include fever, rash, urticaria, edema, erythema multiforme, erythema nodosum, and skin eruptions. These reactions may occur at any time during treatment with LEVAQUIN, even after several months or years of use. Photosensitivity reactions range from mild to severe. Typically, they involve the skin and may be associated with fever, malaise, or other symptoms. In rare cases, they have been fatal. Photosensitivity reactions may occur even in patients who have never had such reactions to other medications. Photosensitivity reactions may occur with or without sun exposure. Patients should be instructed to avoid excessive sunlight or other sources of ultraviolet radiation while on treatment with LEVAQUIN. Patients should be instructed to immediately seek medical attention if they develop a photosensitivity reaction. If possible, patients should be instructed to discontinue LEVAQUIN if a photosensitivity reaction occurs. Tendonitis and tendon rupture have been reported with LEVAQUIN and other quinolones. Patients should be instructed to report any evidence of pain or weakness in a tendon promptly. If possible, patients should discontinue LEVAQUIN and consult their healthcare provider. A patient with known or suspected tendonitis or tendinopathy may experience pain in a tendon, such as the Achilles tendon of the leg, or may experience symptoms of pain, redness, swelling, and weakness in a tendon. The possibility of exacerbation or triggering of tendonitis or tendinopathy should be considered prior to using LEVAQUIN in a patient who has known or suspected tendonitis or tendinopathy. Patients who develop pain or weakness in a tendon should discontinue LEVAQUIN and consult their healthcare provider. If a patient has known or suspected tendonitis or tendinopathy, the healthcare provider should consider whether to use LEVAQUIN for the treatment of an infection.

Additional adverse events reported from worldwide postmarketing experience with LEVAQUIN include: allergic pneumonitis, anaphylactic shock, angioedema, anaphylaxis, angioneurotic edema, atopy, exacerbation of inflammatory bowel disease, exacerbation of lupus-like syndrome, fever, lichen planus, lupus-like syndrome, maculopapular rash, myasthenia gravis, polynuclear leukocytosis, purpura, red man syndrome, Stevens-Johnson syndrome, and toxic epidermal necrolysis.

ADVERSE REACTIONS.

Information for Patients and Adverse Reactions

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### Indications:

† LEVAQUIN is indicated for adults with community-acquired pneumonia due to *S. aureus*, *S. pneumoniae* (including multidrug-resistant strains [MDRSP]), *H. influenzae*, *H. parainfluenzae*, *K. pneumoniae*, *M. catarrhalis*, *M. pneumoniae*, *C. pneumoniae*, or *L. pneumophila*.

‡ MDRSP (multidrug-resistant *S. pneumoniae*) isolates are strains resistant to two or more of the following antibiotics: penicillin (MIC ≥ 2 μg/mL), 2nd generation cephalosporins, eg, cefuroxime, macrolides, tetracyclines, and trimethoprim/sulfamethoxazole.

§ Efficacy of this alternative regimen has been demonstrated to be effective for infections caused by *S. pneumoniae* (excluding MDRSP), *H. influenzae*, *H. parainfluenzae*, *M. pneumoniae*, and *C. pneumoniae*.

### Important Safety Information

The most common drug-related adverse events in US clinical trials were nausea (1.5%) and diarrhea (1.2%).

The safety and efficacy of levofloxacin in pediatric patients, adolescents (under 18), pregnant women, and nursing mothers have not been established. Levofloxacin is contraindicated in persons with a history of hypersensitivity to levofloxacin, quinolone antimicrobial agents, or any other components of this product. Serious and occasionally fatal events, such as hypersensitivity and/or anaphylactic reactions, as well as some of unknown etiology have been reported in patients receiving therapy with quinolones, including levofloxacin. These reactions may occur following the first dose or multiple doses. The drug should be discontinued at the first appearance of a skin rash or any other sign of hypersensitivity.

As with other quinolones, levofloxacin should be used with caution in patients with known or suspected central nervous system disorders, peripheral neuropathy, or in patients who have a predisposition to seizures.

Tendon ruptures that required surgical repair or resulted in prolonged disability have been reported in patients receiving quinolones, including levofloxacin, during and after therapy. This risk may be increased in patients receiving concomitant corticosteroids, especially the elderly. The quinolone should be discontinued in patients experiencing pain, inflammation, or rupture of a tendon.

Some quinolones, including levofloxacin, have been associated with prolongation of the QT interval, infrequent cases of arrhythmia, and rare cases of torsades de pointes. Levofloxacin should be avoided in patients with known risk factors such as prolongation of the QT interval, patients with uncorrected hypokalemia, and patients receiving class IA (quinidine, procainamide), or class III (amiodarone, sotalol) antiarrhythmic agents.

Antacids containing magnesium or aluminum, as well as sucralfate, metal cations such as iron, and multivitamin preparations with zinc, or Videx® (didanosine) chewable/buffered tablets or the pediatric powder for oral solution, should be taken at least 2 hours before or 2 hours after levofloxacin administration.

For information on Warnings, Precautions, and additional Adverse Reactions that may occur, regardless of drug relationship, please see full Prescribing Information.