JUCM™
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IN THIS ISSUE

MANAGEMENT OF Acute Orofacial Pain Syndromes

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LETTER FROM THE EDITOR-IN-CHIEF

Why I Practice Urgent Care Medicine

Nothing represents the breadth and scope of medicine quite like urgent care.

The variety of complaints is daunting and requires a lifelong commitment to learning. Specialist back-up is scarce and diagnostics limited. Ultimately, the best care stems from a passion for examining the layers of each story, watching, listening, and compiling.

Cultural, gender, and age biases can serve to guide our investigations or derail them:

- Where is this patient coming from?
- How are they interacting with others in the room?
- What do they think is wrong with them?
- What do they think will help them?
- What are their misconceptions of medicine?

If we don't take the time to reflect on the subtle clues our patients are giving us, we stand to miss the one opportunity we have to help them.

Consider the following:

20-year-old female with shortness of breath and dizziness
Severe underlying depression for years, as of yet undiagnosed and untreated. Drinks 10 Diet Cokes per day, frequently skips breakfast, and smokes a pack of cigarettes per day. No other findings of organic illness. Diagnoses:
1.) Panic attacks
2.) Major depressive disorder
3.) Caffeine and nicotine dependence

The patient is shocked that we can actually help her; she never knew how her lifestyle and depression could contribute to such disabling physical symptoms. On the way out, she comments that she feels hopeful for the first time in years.

34-year-old male with shortness of breath and dizziness
History reveals a physically active male with no medical problems but whose father died "naturally" in his 40's. The patient denies chest pain and has a normal EKG. Initial cardiac enzymes negative.

Nonetheless, he is admitted to hospital on suspicion of coronary artery disease. Catheterization reveals extensive three-vessel disease.

The patient undergoes coronary bypass surgery, and maintains a physically active life without any complication.

80-year-old male with shortness of breath and dizziness
On multiple medications for blood pressure, all of which he believes he is taking appropriately. Exam reveals a pulse of 38 bpm.

The patient is later found to have taken too much Lopressor.

70-year-old widow with shortness of breath and dizziness
Extensive history and physical reveal no clear underlying cause. She spends most of our encounter sharing stories of her late husband, asking if I am married (which I am) or if I am related to any of the "other" Resnicks in Cleveland (which invariably I am not).

There is no diagnosis. There has been no recurrence, to date. But she does drop off a box of chocolates for all my "fine work."

Four patients with the same complaint, but wildly different causes.

This is urgent care, the ultimate in investigative medicine: gathering evidence, evaluating clues, trusting your gut, posing hypotheses....

Every complaint, no matter how benign, represents a potential life-changing event for patients and physicians alike. We are at the front lines.

If we are right, we can be the hero. If we are wrong, the goat. We have the nearly impossible task of establishing the trust of a complete stranger, identifying their agenda, evaluating their problem, and curing what ails them (or explaining why we can't) all in about 10 minutes.

This is what keeps me up at night, yet, keeps me going. This is the challenge and joy of urgent care. There is nothing else like it in medicine.

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

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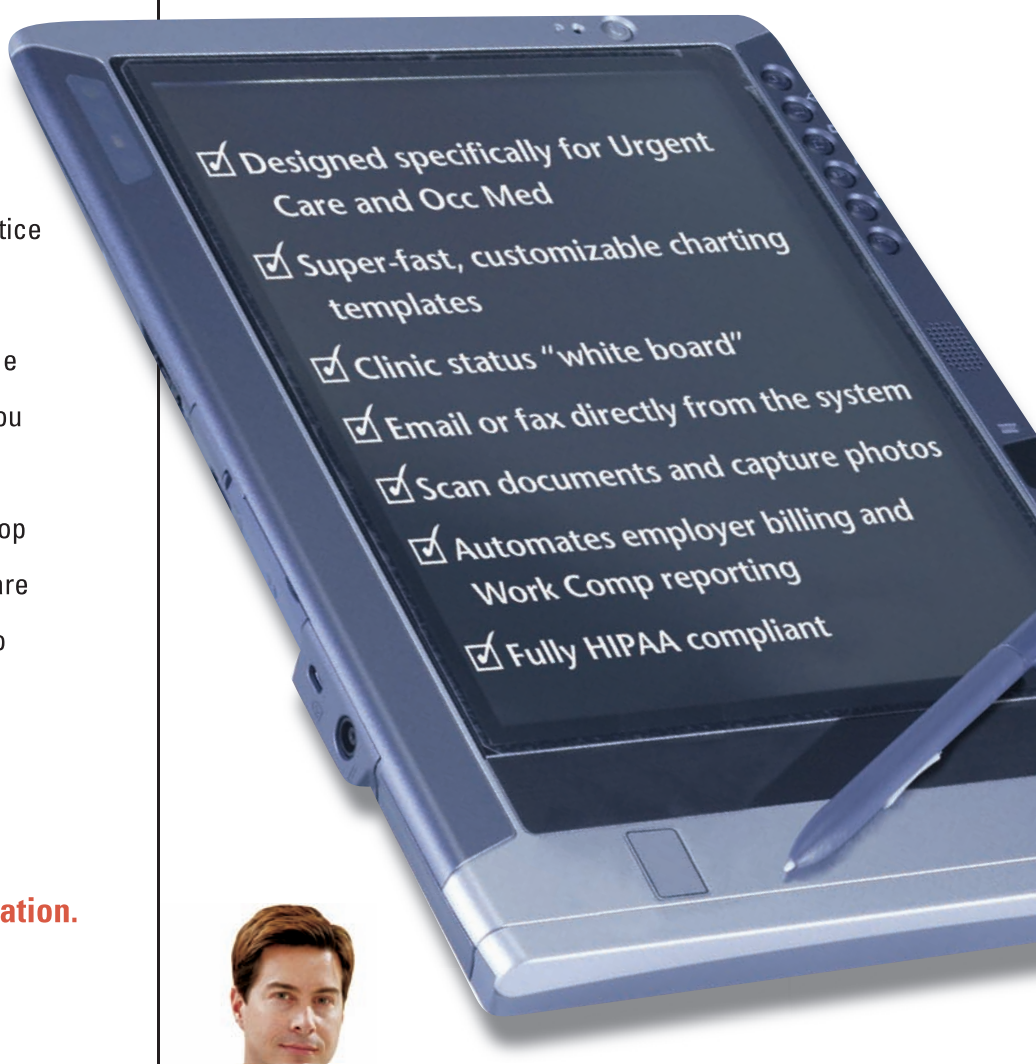

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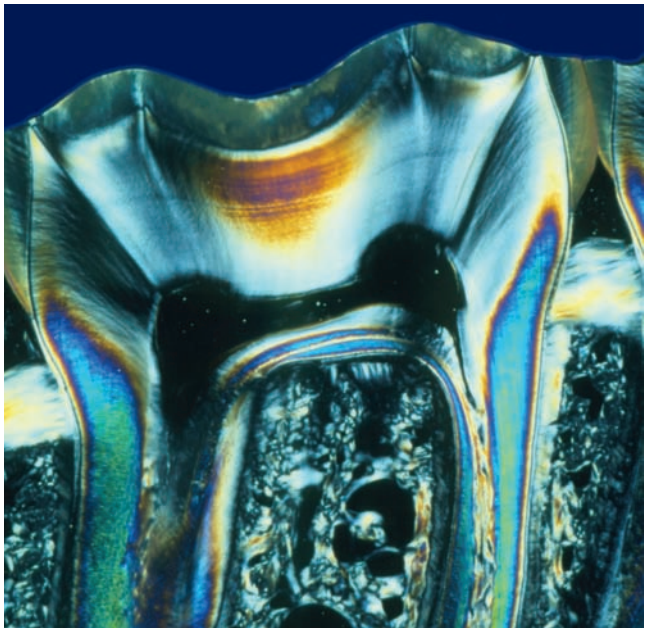

CLINICAL

9 Management of Acute Orofacial Pain Syndromes

Patients presenting with acute pain in the mouth or teeth can pose a challenge for the urgent care physician, especially if the source is something other than obvious dental trauma. A discussion of the differential diagnosis and recommended management.

By John A. Vaughn, MD

17 Telephone Consultations From the Urgent Care Center:

An Educational Model

Telephone consultations offer an opportunity for good patient management and positive reinforcement of the role urgent care physicians play—when handled properly. A uniform approach like the one presented here might increase the odds of success.

By Kenneth V. Iserson, MD, MBA, FACEP, FAAEM

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Mission Statement

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

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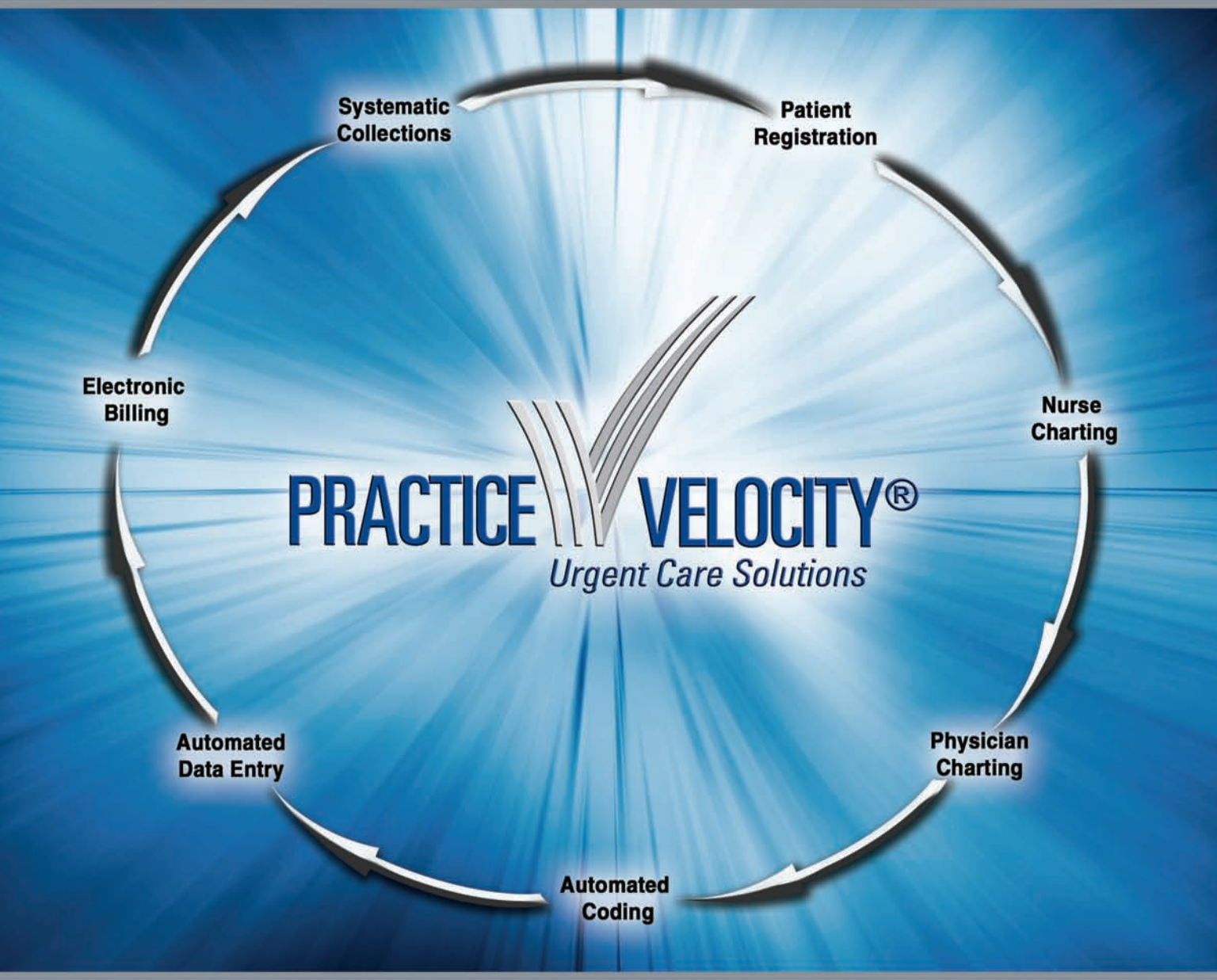

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The author of this month's cover article, Management of Orofacial Pain Syndromes (page 9), is no stranger to the written word. **John Vaughn, MD** has written personal essays and book reviews for such physician-oriented publications as *Medical Economics* and *Diversion*, as well as newspapers including the *Los Angeles Times*, *San Francisco Chronicle*, *Baltimore Sun*, and *The Plain Dealer* (Cleveland, Ohio). First and foremost, though, he is an urgent care physician with Immediate Health Associates in Westerville, Ohio and is affiliated with Mt. Carmel Health Systems. A member of the Ohio Academy of Family Physicians and the American Academy of Family Physicians, he has a special interest in performance improvement/risk management, medical humanities, and creative writing.

And **Ken Iserson, MD, MBA, FACEP, FAAEM** is no stranger to *JUCM*. In addition to sitting on our Advisory Board, Dr. Iserson wrote the cover article for our premier issue in October 2006. He is a professor of emergency medicine and director of the Arizona Bioethics Program at the University of Arizona in Tucson. Additional areas of clinical interest include bioethics and disaster medicine. He has authored several books (*Demon Doctors: Physicians as Serial Killers* and *Death to Dust: What Happens to Dead Bodies?* to name just two) and also serves on the State of Arizona's Disaster Medical Assistance Team. His latest contribution to *JUCM*, Telephone Consultations from the Urgent Care Center: An Educational Model, begins on page 17.

In support of our mission to bring you content that covers the breadth of concerns common to the urgent care practitioner, we are adding a new feature this month: **Kevin Ralofsky, MBA** is contributing the first of what will be a series of columns on Business & Medicine. He may be familiar to you as the treasurer of the Urgent Care Association of America, as a speaker, or as the author of an article on financial issues in urgent care that appeared in the December issue of *JUCM*. He joins **Nahum Kovalski, BSc, MDCM** of Terem Immediate Medical Care in Jerusalem, Israel; **John Shufeldt, MD, JD, 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, on our panel of regular contributors to *JUCM*.

Finally, in case you missed it a few pages back, our editor-in-chief, **Lee Resnick, MD** continues his running commentary on issues that speak to the essence of the practice of urgent care medicine (page 1), this month discussing the challenges that keep him engaged as a provider.

We'd like to know what keeps you engaged as a practitioner of urgent care medicine and, hopefully, as a reader of *JUCM*. Send a Letter to the Editor via e-mail to *editor@jucm.com* and let us know your thoughts on the state of the specialty or your opinion on *JUCM*.

To Submit an Article to *JUCM*

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

Manuscripts on clinical or practice management topics should be 2,600–3,200 words in length, plus tables, figures, pictures, and references. Articles that are longer than this will, in most cases, need to be cut during editing.

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

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

To Subscribe to *JUCM*

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To Find Urgent Care Job Listings

If you would like to find out about job openings in the field of urgent care, or would like to place a job listing, log on to *www.jucm.com* and click on "Urgent Care Job Search."

Have Your Sites Set

LOU ELLEN HORWITZ, MA

Look out, world.

Have you "Googled" the term *urgent care* lately? You get about 2,870,000 results. (To keep things in perspective, entering the word *Beatles* yields about three times as many results; still, they've got a few years on us so we can work on that.)

Try this: enter the words "urgent care (your city)" and see what happens. Does your clinic's website come up? Does your clinical even *have* a website?

I can say with certainty that many of you do not, and that most who do are buried in the massive pile of 2,869,999 other listings that have some relationship to urgent care.

In many cases, I can put in the exact name of your clinic and get somewhere between zero and completely meaningless results. Sometimes a phonebook or map listing will appear on screen, but that's it.

So what does this mean for you? Hint: Your potential patients are having the same experience.

While not everyone uses the Internet to search for health information, about 80% of Americans do,[1] and if you want them to find you, you need to work at it a little.

Here are a few suggestions:

1. As intimated above, have a website. If you don't have one, get one. Even if the only thing someone sees on screen is your clinic name, hours of operation, directions, and a phone number, that's enough to help get them to your location. If they've come this far, surely they'll take the next step and pick up the phone or get to your location.
2. Make it clean and quick. This is not the time to spend money on fancy spinning graphics—put yourself in the place of the patient or worried family member looking for somewhere to go for care. Remember, if they're looking for you, they need your help.
3. Make it reflective of your clinic and overall marketing strategy. If you are a pediatric clinic and want to attract the appropriate patients, put some time into a "look" to the site that will communicate friendliness and quality. If you are targeting a geriatric population, be sure you have big type and maybe photos of staff to make the potential patient less worried about not seeing "their doctor."

Health Topics Searched Online[1]

Subject of Internet Search	% of Internet Users
Specific disease or medical problem	64%
Certain medical treatment or procedure	51%
Prescription or OTC drugs	37%
A particular doctor or hospital	**29%**
Environmental health hazards	22%
Medicare or Medicaid	13%

These are just the basics, of course. If you'd like to move to the next step with online pre-arrival check-in to allow patients to get on a priority list, or other bells and whistles, by all means go for it!

Ask your community what they'd like to see in order to help you help them more effectively and efficiently.

And while you're at it, "Google" your main competitor. For some, those results may be the best motivation of all to get moving on your own site. ■

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

Reference
1. "Online Health Search 2006". Fox, S., Pew Internet & American Life Project, October 29, 2006.

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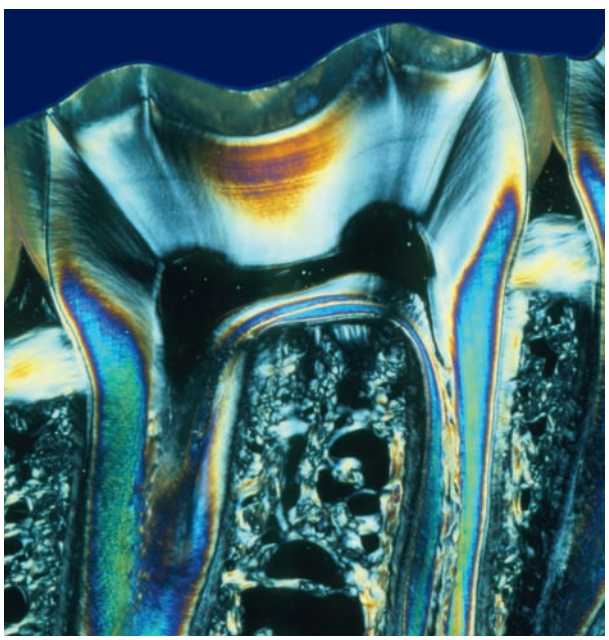
Clinical

Management of Acute Orofacial Pain Syndromes

Urgent message: The differential diagnosis of acute orofacial pain is wide ranging; prompt recognition of these syndromes is vital for ensuring the best possible outcome.

John A. Vaughn, MD, Immediate Health Associates, Westerville, OH

Acute orofacial pain—pain arising from the teeth or soft tissues of the mouth—is extremely common, affecting 22% of people in the United States.[1] Since it is more likely to affect younger adults and those without adequate access to primary care, it is a frequent presenting complaint in emergency departments and urgent care centers. While there are few true emergencies, the differential diagnosis of acute orofacial pain is wide ranging, and prompt recognition of these syndromes is vital for ensuring the best possible outcome.



This article will provide an introduction to some of the more likely origins of acute orofacial pain, and suggest appropriate management and "next steps" in the urgent care setting.

Dental Pain

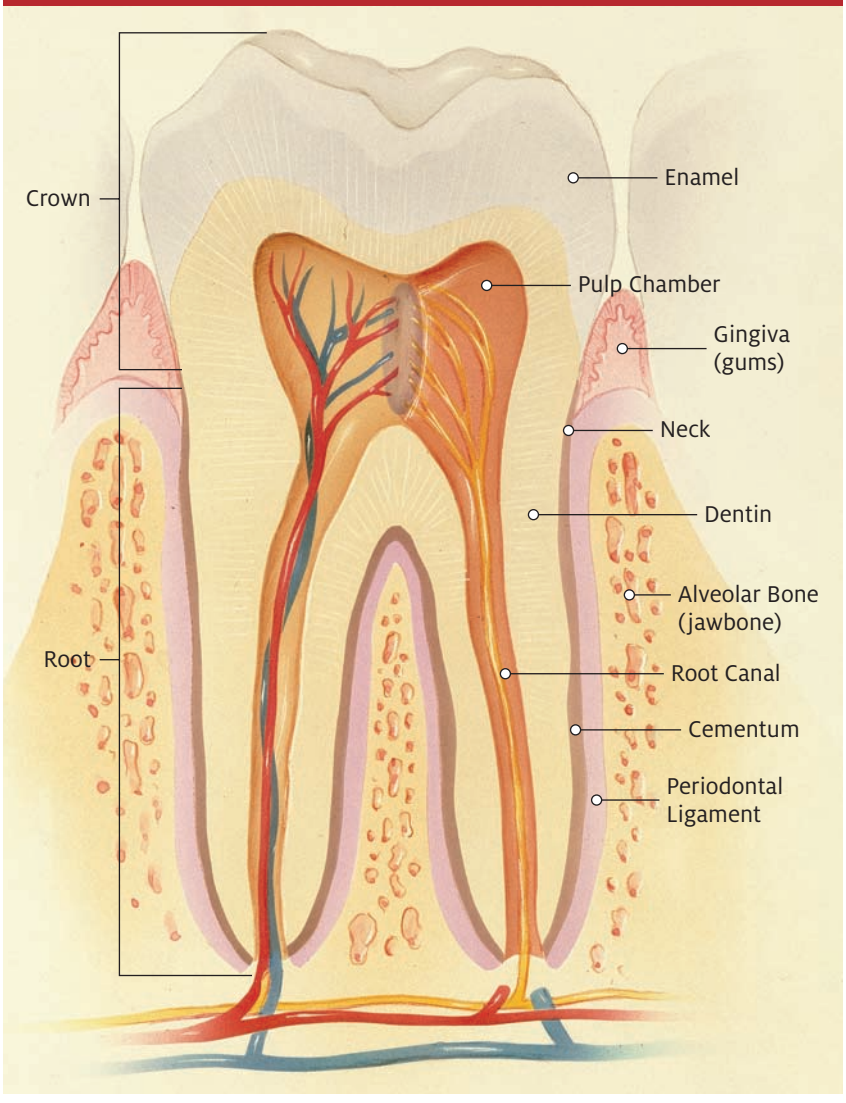
Dental pain is responsible for over 700,000 ED visits a year.[2] While non-odontogenic sources such as maxillary sinusitis, migraine headaches, temporomandibular joint (TMJ) syndrome, and neuralgias can cause referred teeth pain, dental sources are the most common. A basic illustration of dental anatomy is presented in **Figure 1**.

Pathology of Carious Origin

Dietary carbohydrates on the crown surface are metabolized by oral bacteria, most predominantly *Streptococcus mutans*. Prolonged exposure to these acidic metabolic byproducts leads to an erosion of the enamel layer referred to as *dental caries* (cavities). Dental caries is treated by removal of the carious tissue and replacement with a filling by a dentist.

Dental caries is asymptomatic until the erosion breaches the pulp chamber, when it causes an inflammatory process called *reversible pulpitis*. Reversible pulpitis is characterized by pain triggered by thermal, sweet, or sour stimuli that typically lasts for only a few seconds. If left untreated, it will progress to *irreversible pulpitis*, in which the pain is more severe, lasts longer, and is more diffuse.

Figure 1



Continued inflammation will lead to pulp necrosis and apical periodontitis, in which the pain becomes even more severe, will re-localize to the affected tooth, and can be associated with regional lymphadenopathy. Apical periodontitis can become purulent and lead to the formation of an apical abscess, which is often associated with buccal or palatal fluctuance.

Definitive treatment of apical periodontitis and apical abscess is root canal therapy or tooth extraction. Management in the urgent care setting should include providing adequate pain control and arranging follow-up with a dentist within one to two days. If there is evidence of cellulitis, an antistreptococcal antibiotic should be prescribed: penicillin VK 500 mg TID-QID (50 mg/kg divided into three or four doses in children), clindamycin 300 mg QID, or erythromycin 500 mg QID.[3]

Ludwig's Angina

A patient whose clinical presentation is consistent with an abscess involving the mandibular teeth should be carefully evaluated for Ludwig's angina, a potentially life-threatening, rapidly expanding cellulitis of the submandibular and sublingual spaces.

As the floor of the mouth becomes inflamed and indurated, the tongue is elevated and pushed posteriorly leading to airway obstruction. Ludwig's angina is typically bilateral and patients present with fever, neck swelling, drooling, trismus, pain, dysphagia, and dyspnea.[4]

The cornerstone of Ludwig's angina management in the urgent care setting is airway protection until the patient can be transported by EMS to an ED for surgical consultation. Treatment involves IV antibiotics, IV steroids, and, if necessary, incision and drainage and surgical decompression with tracheotomy. High-dose penicillin G is the antibiotic of choice, typically administered with an antistaphylococcal drug and metronidazole for anaerobe coverage.[5]

Acute Alveolar Osteitis

Acute alveolar osteitis, or dry socket, results from the loss of the protective blood clot that forms in the alveolar socket after a tooth extraction. Patients typically present two to three days postextraction with complaints of acute pain and foul odor. Exam will reveal a dry appearance of the exposed bone in the alveolar socket.

Management is supportive until the patient can follow up with the dentist. The socket can be gently rinsed with warmed saline or chlorhexidine (Peridex) to remove any debris and packed with moistened iodoform gauze or gauze soaked with eugenol. Packing should be changed daily, and appropriate analgesia should be prescribed.

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*Based on pharmacokinetic data.[1]
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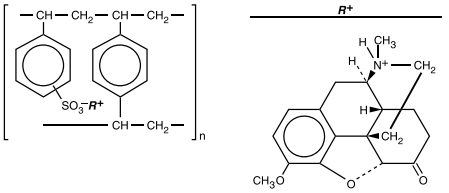
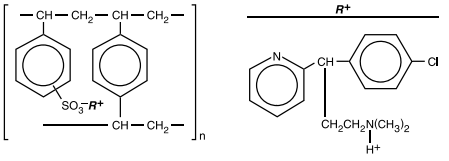
Hydrocodone Polistirex: sulfonated styrene-divinylbenzene copolymer complex with 4,5α-epoxy-3-methoxy-17-methylmorphinan-6-one.



Chlorpheniramine Polistirex: sulfonated styrene-divinylbenzene copolymer complex with 2-[*p*-chloro-α-[2-(dimethylamino)ethyl]-benzyl]pyridine.



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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. The effects of hydrocodone in therapeutic doses on the cardiovascular system are insignificant. Hydrocodone can produce miosis, euphoria, physical and psychological dependence.

Chlorpheniramine is an antihistamine drug (H_1 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 allergy 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 postoperatively and in patients with pulmonary disease or whenever ventilatory function is depressed. If respiratory depression occurs, it may be antagonized by the use of naloxone hydrochloride and other supportive measures when indicated (see OVERDOSAGE).

Head Injury and Increased Intracranial Pressure: The respiratory depressant effects of narcotics and their capacity to elevate cerebrospinal fluid pressure may be markedly exaggerated in the presence of head injury, other intracranial lesions 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 depressant action of narcotic cough suppressants in a dose-dependent manner. Benefit to risk ratio should be carefully considered especially in pediatric patients with respiratory embarrassment (e.g., croup) (see PRECAUTIONS).

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, hypothyroidism, Addison's disease, prostatic hypertrophy or urethral stricture. The usual precautions should be observed and the possibility of respiratory depression should be kept in mind.

Information for Patients: As with all narcotics, TUSSIONEX Pennkinetic Extended-Release Suspension may produce marked drowsiness and impair the mental and/or physical abilities required for the performance of potentially hazardous tasks such as driving a car or operating machinery; patients should be cautioned accordingly. TUSSIONEX Pennkinetic Extended-Release Suspension must not be diluted with fluids or mixed with other drugs as this may alter the resin-binding and change 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, antihistaminics, antipsychotics, antianxiety agents or other CNS depressants (including alcohol) concomitantly with TUSSIONEX Pennkinetic Extended-Release Suspension may exhibit an additive CNS 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 effect of either the antidepressant or hydrocodone.

The concurrent use of other anticholinergics with hydrocodone may produce paralytic ileus.

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.

Pregnancy: Teratogenic Effects – Pregnancy Category C. Hydrocodone has been shown to be teratogenic in hamsters when given in doses 700 times the human dose. There are no adequate and well-controlled 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 stools, 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 excreted in human milk. Because many drugs are excreted in human milk and because of the potential for serious adverse reactions in nursing infants from TUSSIONEX Pennkinetic Extended-Release Suspension, a decision should be made whether to discontinue nursing or to discontinue the drug, taking into account the importance of the drug to the mother.

Pediatric Use: Safety and effectiveness of TUSSIONEX Pennkinetic Extended-Release Suspension in pediatric patients under six have not been established (see WARNINGS).

Geriatric Use: Clinical studies of TUSSIONEX did not include sufficient numbers of subjects aged 65 and over to determine whether they respond differently from younger subjects. Other reported clinical experience has not identified differences in responses between the elderly and younger patients. In general, dose selection for an elderly patient should be cautious, usually starting at the low end of the dosing range, reflecting the greater frequency of decreased hepatic, renal, or cardiac function, and of concomitant disease or other drug therapy.

This drug is known to be substantially excreted by the kidney, and the risk of toxic reactions to this drug may be greater in patients with impaired renal function. Because elderly patients are more likely to have decreased renal function, care should be taken in dose selection, and it may be useful to monitor renal function.

ADVERSE REACTIONS: Central Nervous System: Sedation, drowsiness, mental clouding, lethargy, impairment of mental and physical performance, anxiety, fear, dysphoria, euphoria, dizziness, psychic dependence, mood changes.

Dermatologic System: Rash, pruritus.

Gastrointestinal System: Nausea and vomiting may occur; they are more frequent in ambulatory than in recumbent patients. Prolonged administration of TUSSIONEX Pennkinetic Extended-Release Suspension may produce constipation.

Genitourinary System: Ureteral spasm, spasm of vesicle sphincters and urinary retention have been reported with opiates.

Respiratory Depression: TUSSIONEX Pennkinetic Extended-Release Suspension may produce dose-related respiratory depression by acting directly on brain stem respiratory centers (see OVERDOSAGE).

Respiratory System: Dryness of the pharynx, occasional tightness of the chest.

DRUG ABUSE AND DEPENDENCE: TUSSIONEX Pennkinetic Extended-Release Suspension is a Schedule III 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 overdosage with hydrocodone is characterized by respiratory depression (a decrease in respiratory rate and/or tidal volume, Cheyne-Stokes respiration, cyanosis), extreme somnolence progressing to stupor or coma, skeletal muscle flaccidity, cold and clammy skin, and sometimes bradycardia and hypotension. Although miosis is characteristic of narcotic overdose, mydriasis may occur in terminal narcosis or severe hypoxia. In severe overdosage apnea, circulatory collapse, cardiac arrest and death may occur. The manifestations of chlorpheniramine overdosage may vary from central nervous system depression to stimulation.

Treatment: Primary attention should be given to the reestablishment of adequate respiratory exchange through provision of a patent airway and the institution of assisted or controlled ventilation. The narcotic antagonist naloxone hydrochloride is a specific antidote for respiratory depression which may result from overdosage 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 1 teaspoonful in 24 hours.

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

HOW SUPPLIED: TUSSIONEX Pennkinetic (hydrocodone polistirex and chlorpheniramine polistirex) Extended-Release Suspension is a gold-colored suspension.

NDC 53014-548-67 473 mL bottle

Shake well. Dispense in a well-closed container. Store at 59°-86°F (15°-30°C).

CELLTECH

Celltech Pharmaceuticals, Inc.
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Rev. 12/02
Tussionex® Pennkinetic® Extended-Release Suspension: US Patent No. 4,762,709.2. LR242A

Gingivitis

Chronic accumulation of plaque along the gingival margins in patients with inadequate oral hygiene will lead to inflammation and bleeding. As gingivitis progresses, the inflammation can destroy the periodontal ligament and surrounding alveolar bone. This chronic periodontitis leads to tooth loss and an increased risk of developing acute periodontal abscesses from debris becoming lodged in the periodontal pocket.

Patients with an acute periodontal abscess will typically present with pain, erythema, and edema over the affected segment. The tooth is typically tender to percussion and hyper-mobile. Treatment includes warm saline rinses and referral to a dentist within 24 hours for incision and drainage. If there is any evidence of cellulitis, patients should be started on oral penicillin or erythromycin.

Acute necrotizing ulcerative gingivitis (ANUG, or "trench mouth") is a rapidly spreading gingival infection caused by an overgrowth of normal oral bacteria including alpha-hemolytic *streptococci*, *Prevotella intermedia,* and *Actinomyces* species. When ANUG spreads beyond the gingiva, it is referred to as *noma*, or *cancrum oris*. As an opportunistic infection, ANUG typically affects immunosuppressed patients with poor diet and poor oral hygiene.

Patients usually complain of pain, spontaneous gingival bleeding, foul breath, or alterations in taste. The classic physical findings are gingival edema and ulceration in the interdental papillae (often associated with a gray pseudomembrane), halitosis, and fever.

Treatment includes saline or diluted hydrogen peroxide rinses, topical lidocaine, oral analgesics for pain relief, and oral antibiotics. Penicillin VK is the drug of choice (or erythromycin if the patient is allergic to penicillin). Patients should follow up with a dentist in one to two days.[6]

Dental Trauma

Dental trauma is extremely common; it is estimated that 50% of all children experience some form of dental trauma.[7] Assessment of dental injuries should always include establishing the mechanism and timing of the injury, evaluation for the presence of associated soft tissue injuries or bite malocclusion, and dental radiography to rule out a fracture if available.

Dental Fractures

Dental fractures may involve the crown, root, or alveolar bone. Adequate analgesia should be prescribed and dental follow-up arranged within one to two days. Fractures that expose the pulp may be more painful, but do not necessarily require emergent consultation.

Displacement Injuries

While displacement injuries of primary teeth have minimal long-term sequelae, displacement injuries of permanent teeth are dental emergencies whose prognosis directly correlates with timeliness of treatment.

Intrusive luxation is the displacement of the tooth into the alveolar socket. Since the tooth should be allowed to spontaneously re-erupt prior to any attempts at realignment, tetanus prophylaxis and pain control is all that is required in the urgent care setting. The patient should be non-emergently referred to a dentist for monitoring and potential root canal treatment.

"Displacement of permanent teeth is a dental emergency; prognosis correlates with timeliness of treatment."

Lateral or extrusive luxation is the loosening and displacement of the tooth within the alveolar socket. In the primary dentition, if the tooth is loose enough that it could be aspirated or cause malocclusion the patient should be referred to a dentist for immediate extraction.[8] In the permanent dentition, the patient should be emergently referred to a dentist or oral surgeon for repositioning and splinting. Patients should be placed on appropriate analgesics and antibiotic prophylaxis, and tetanus status addressed.

Avulsion is the complete displacement of the tooth out of the alveolar socket and is a time-sensitive dental emergency; successful reimplantation is less likely if the tooth has been out of the socket for more than 20 minutes.

Primary teeth should never be re-implanted. Permanent teeth should be re-implanted as soon as possible. The tooth should be gently rinsed in sterile saline prior to re-implantation and should only be handled by the crown; any manipulation of the root could disrupt the periodontal ligament fibers that are vital for re-attachment. Antibiotic prophylaxis should be prescribed, tetanus status addressed, and emergent dental consultation for splinting and follow-up management should be made.

If the tooth cannot be re-implanted in the urgent care center, it should be transported with the patient to the consultant in a specialized tooth transport apparatus. If this is unavailable, milk can be used as a transport medium; it is relatively sterile and has pH and osmolality levels compatible enough with periodontal ligament cells to keep them viable for up to three hours.[9] Using sterile saline or having the patient carry the tooth in the buccal sulcus is also a reasonable alternative for transport.

Stomatitis

Over a third of acute orofacial pain syndromes are caused by mouth sores.[10] While the differential diagnosis is extensive, the following are among the most common causes seen in the urgent care setting.

Oral Candidiasis

Oral candidiasis ("thrush") is caused by an overgrowth of the ubiquitous fungus *Candida albicans*. Predisposing factors include: the extremes of age, the use of intra-oral prosthetic devices, recent antibiotic use, and immunosuppression. Patients typically present with white plaques overlying an erythematous base on the buccal mucosa and tongue that can be easily scraped away with a tongue depressor. Treatment includes topical or oral antifungal agents, as follows:

- Nystatin (Mycostatin) 100,000 Units/mL. Adults: 4-6 mL swish and swallow QID. (Infants: 2 mL QID).
- Mycostatin Pastilles 200,000 Units. 1-2 Pastilles dissolved slowly in mouth QID.
- Fluconazole (Diflucan) 200 mg po QD on day 1, then 100 mg po QD for at least 14 days. (Peds: 6 mg/kg po QD on day one, then 3 mg/kg po QD.)

"Over a third of acute orofacial pain syndromes are caused by mouth sores; the differential diagnosis is extensive."

Aphthous Stomatitis

Aphthae are associated with nutritional deficiencies (iron, folate, B-12), Celiac disease, Crohn's disease and Bechet syndrome, but the etiology of recurrent aphthous stomatitis (RAS, or canker sores) is still unknown. They are extremely painful, well-circumscribed round/oval ulcerations with erythematous borders and yellow or gray bases typically measuring 2-4 mm in diameter.

RAS will resolve spontaneously in seven to 10 days. Topical steroids or viscous lidocaine may be used for supportive care, as follows:

- Dexamethasone (Decadron) elixir 0.5 mg/5 mL. 5 mL swish and spit QAC and QHS.
- Triamcinolone (Aristocort) gel 0.1%; apply two to four times daily.
- Fluocinonide (Lidex) gel 0.5%; apply two to four times daily.
- Lidocaine Viscous 2% gel; apply Q 4 hours prn.

Another treatment option is chemical cautery of the lesion with silver nitrate. This has been shown to reduce pain, although it has no statistically significant effect on healing time.[11]

Herpes Simplex

Herpes labialis ("fever blisters" or "cold sores") is caused by the Herpes simplex virus (HSV). The type 1 virus is responsible for the majority of cases, but type 2 may also cause oral lesions. Most people have been infected with the virus by adulthood.

HSV stomatitis presents as painful, grouped vesicles on the gingiva, buccal mucosa, lips, or tongue that may extend onto the peri-oral skin. The vesicles quickly rupture to form small ulcerations that will develop a yellow- to honey-colored crust and heal spontaneously over two to three weeks. The pathognomonic feature is a tingling, burning or itching pain that develops in the affected area one to two days before the lesions erupt.

Treatment is supportive. If started during the prodromal phase, antiviral medications have been shown to shorten the course and lessen the severity of the outbreak. Topical antivirals are much less effective. Typical administration is as follows:

- Acyclovir (Zovirax) 400 mg PO TID (or 800 mg PO BID) for five days.
- Valacyclovir (Valtrex) 2 g PO Q12 hours for one day (total of 4 g).

Herpangina

Herpangina is an acute febrile illness caused by coxsackievirus group A that most commonly affects children in the summer months. Patients develop fever, sore throat, headache, cervical lymphadenopathy, and malaise which is followed by the eruption of multiple vesicles on the soft tissues of the posterior pharynx. These vesicles rupture, leaving multiple

ulcerations which may last for a week. Unlike herpes labialis and RAS, herpangina lesions do not appear on the gingiva, tongue, or anterior buccal mucosa.

Hand, Foot, and Mouth Disease

Hand, foot, and mouth disease (HFM) is the most common cause of mouth sores in children.[12] It is a highly contagious acute febrile illness caused by enteroviruses—typically coxsackievirus A16—that usually affects children under the age of 5 with a peak incidence in summer and fall.

After a prodrome of fever, malaise, and sore mouth, painful vesicular lesions that rupture to form shallow ulcers with an erythematous halo will develop on the buccal mucosa, tongue, gingiva, and soft palate. The distinguishing feature of HFM is the presence of a rash on the hands and feet (and often the buttocks). This rash begins as erythematous macules—classically on the palmar and plantar surfaces—that progress to gray vesicles on an erythematous base which may be asymptomatic or pruritic.

HFM is self-limited, usually lasting a week, and treatment is supportive.

Angular Cheilitis

Angular cheilitis is a painful inflammation of the corners of the mouth that involves the formation of deep fissures. Angular cheilitis can be the result of an infectious process (usually fungal) or vitamin B deficiency, but is often due to mechanical irritation: thumb sucking in children, lip licking/biting in adults, or excessive pressure in edentulous patients.

Treatment is aimed at correcting the underlying cause, but patients should be encouraged to keep the areas dry and well-lubricated with an emollient.

Leukoplakia

Although leukoplakia rarely causes pain, as a precancerous lesion it should always be included in the differential diagnosis of a patient with oral lesions. It is a thick, rough, hardened, and slightly raised white patch or plaque that develops on the sides of the tongue or buccal mucosa in response to chronic irritation. If the lesion is red, it is referred to as *erythroplakia*.

Leukoplakia develops over weeks to months and is often asymptomatic. It may become sensitive to touch, heat, or spicy foods. The cause is unknown, but tobacco use—especially pipe smoking and the use of chewing tobacco/snuff—is associated with a high risk of developing leukoplakia. Unlike oral candidiasis, it is adherent and cannot be easily scraped off with a tongue depressor.

The patient with leukoplakia must be non-emergently referred to a dentist or oral surgeon for biopsy evaluation of the lesion. Removal of the underlying irritation may result in complete resolution, but surgical removal of the lesion may be necessary.

Summary

It would behoove the urgent care provider to bear the following key points in mind when treating a patient who has presented with a complaint discussed in this article:

- A patient with an abscess involving the mandibular teeth should be carefully evaluated for Ludwig's angina, a potentially life-threatening condition.
- Displacement injuries of permanent teeth are dental emergencies whose prognosis directly correlates with timeliness of treatment.
- Avulsed primary teeth should never be re-implanted.
- An avulsed tooth should never be handled by the root, as this could disrupt the periodontal ligament fibers that are vital for re-attachment.
- Any patient with an oral lesion suspicious for leukoplakia/erythroplakia must be referred for biopsy evaluation since this is a pre-cancerous lesion. ■

REFERENCES

1. Dental, Oral, and Craniofacial Data Resource Center. *Oral Health U.S., 2002*. Bethesda, Maryland: 2002.
2. Lewis C, Lynch H, Johnston B. Dental complaints in emergency departments: a national perspective. *Ann Emerg Med*. 2003;42:93-99.
3. Beaudreau RW. Oral and Dental Emergencies. In: Tintinalli JE, Kelen GD, Stapczynski JS, eds. *Emergency Medicine: A Comprehensive Study Guide*. 5th ed. McGraw-Hill; 2000:1539-1556.
4. Marcincuk M, Murray A. Deep Neck Infections. *Emedicine*. Available at: *www.emedicine.com/ent/topic669.htm*. Accessed December 6, 2006.
5. Hartmann RW. Ludwig's Angina in Children. *Am Fam Physician*. 1999;60:109-112.
6. Stephen J. Gingivitis. *Emedicine*. Available at *www.emedicine.com/emerg/topic217.htm*. Accessed December 8, 2006.
7. McTigue DJ. Diagnosis and management of dental injuries in children. *Pediatr Clin North Am*. 2000;47:1067-1084.
8. Douglass AB, Douglass JM. Common Dental Emergencies. *Am Fam Physician*. 2003;67:5111-5116.
9. Peng L. Dental, Avulsed Tooth. *Emedicine*. Available at *www.emedicine.com/emerg/topic125.htm*. Accessed December 8, 2006.
10. Dental, Oral, and Craniofacial Data Resource Center. *Oral Health U.S., 2002*. Bethesda, Maryland: 2002.
11. Alidaee MR, Taheri A, Mansoori P, et al. Silver nitrate cautery in aphthous stomatitis: a randomized controlled trial. *Br J Dermatol*. 2005;153:521-525.
12. Dyne P, Kesler Devore H. Pediatrics, Hand-Foot-and-Mouth Disease. *Emedicine*. Available at *www.emedicine.com/emerg/topic383.htm*. Accessed December 9, 2006.

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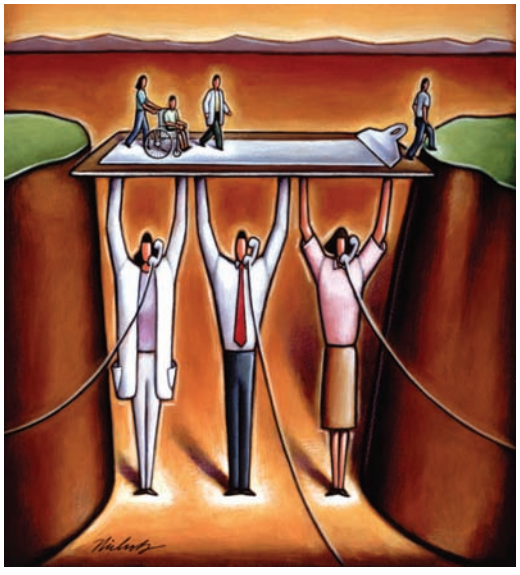
Telephone Consultations From the Urgent Care Center: *An Educational Model*

Urgent message: Communication between UC providers and consultant physicians can facilitate timely, efficacious patient management OR it can damage trust between the treating physician and the consultant.

Kenneth V. Iserson, MD, MBA, FACEP, FAAEM, Professor of Emergency Medicine, The University of Arizona, Tucson, AZ

Introduction

Urgent care providers, as much as or more than any other specialist, must call consultants to admit, refer, appropriately treat, or obtain follow-up for their patients. At many urgent care centers, physicians are also often on the receiving end of calls from providers.



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Such physician-to-physician communication, usually by phone, can enhance patient care but often takes an inordinate amount of time and, if done poorly, can undermine collegial relationships.[1-3] Advances in communication technologies have allowed some medical centers to show some improvement in time management for non-urgent consultations.[4,5]

Despite increased use of e-mail, instant messaging, fax, web-based video conferencing, and radio systems for communication in daily life, the telephone remains the primary medium. Effective telephone consultations with other physicians reflect on the urgent care providers, their group, and their center's professionalism. More importantly, they can facilitate timely and efficacious patient management. Poor physician-to-physician telephone communications, on the other hand, may lead to inappropriate responses from consultants, as well as the urgent care provider garnering the consultant's distrust, a poor professional reputation, and difficulty obtaining such consultations in the future.

At a time when many specialty consultants and other primary care providers are often unwilling to see urgent care patients, unprofessional telephone communication may damage the image physicians want to project. On the other hand, good interactions often lead to professional collegiality, the ability to shorten such interactions based on mutual confidence and respect, and a more efficient working environment—all of which benefit the patient.

With "interpersonal communications" being a core competency of graduate medical education, a simple

method to help teach this important skill would be beneficial.

This paper describes such a model, specifying what to do before the call is made, what to say during the call to conserve time and to get the desired response, and the four possible actions the caller could want from the consultant: to see the patient, to admit the patient, to discuss aspects of the case and to provide insight, and to see the patient in follow-up. Two cases are used to illustrate suboptimal and elegant physician-physician telephone consultations.

Educational Mandate

The Association of American Medical Colleges maintains that a basic goal of medical education is to "develop a base of skills and strategies for working with physician colleagues and other members of the healthcare team."[6]

Similarly, the Accreditation Council for Graduate Medical Education (ACGME) recognizes the importance of interprofessional communication, making it one of their General Requirements applicable to residency programs in all specialties. The requirement states: "The residency program must ensure that its residents by the time they graduate can develop appropriate interpersonal relationships and communicate effectively with patients, their patients' families and professional colleagues."[7]

This is similar to the ACGMR core competency task, "interpersonal and communication skills," to be adapted to all residency programs.[8] Emergency medicine academics have recognized that "communicating with members of the healthcare team is crucial for the emergency physician" and intersects at many points with the "Model of Clinical Practice of Emergency Medicine."[9,10]

Studies have demonstrated that the great potential for communication breakdown between practitioners can have deleterious effects on patient care. Poor communication may be due to lack of formal training, poor communication skills, and time constraints.[11-15]

While some educational models have been used for physician-patient telephone interactions, no formal model has been adopted for consultations between urgent care providers and consultants—a critical and common part of our professional lives.[16] Medical students and residents learn telephone techniques from observation; this, unfortunately, leaves a lot to be desired. The following real-life cases illustrate, first, a typical negative encounter and, second, the most elegant of telephone encounters.

Case 1

The senior medical student calls the pediatric surgeon at 6 p.m. regarding a 9-year-old girl who probably has appendicitis.

Med student: "I have a 9-year-old girl with abdominal pain. She's not pregnant, has a normal urinalysis, and is on no meds…."

Surgeon: "Who is this???"

Med student: "I am Max Tern, a fourth-year student on rotation at Sunrise Urgent Care. My patient lives with her parents, has no allergies…."

Surgeon: "What do you want???"

Med student: "My patient has abdominal pain and we'd like you to see her."

Surgeon: "Does she have an acute abdomen? Has she had any imaging? What are her labs?"

Med student: "Um, I'll have to check."

Surgeon: [Click.]

The surgeon then angrily calls the attending physician.

Case 2

The urgent care physician calls the cardiologist at 10 p.m. regarding a 70-year-old man with aortic stenosis and true syncope.

Urgent care physician: "Bob, this is Jim at Sunrise Urgent Care. I have a 70-year-old man with severe aortic stenosis and true syncope. He's stable now, normal ECG, and has an IV and is on a monitor. The ambulance should be here shortly."

Cardiologist: "OK, can you fax the information to admissions? I'll arrange a CCU bed and, if nothing unusual turns up, I'll probably cath him in the morning."

An Educational Model

The following method is similar to one that most experienced physicians use naturally. In the format below, it can be easily taught and learned by telephone-consultation novices working in urgent care centers. It could also be used to teach physicians whose practice will involve calling into urgent care centers or to other consultants with referrals or for advice.

To derive the most educational value from this method, implement it just before a trainee makes such a call or just after the preceptor listens to a telephone consultation from a resident, student, or new primary provider that fails in one or more of the key elements. Using the model within moments of the less-than-optimal phone interaction reinforces the learning process.

Before the Call

A. Know *what you want* from the consultant; i.e., why are you calling? There are only four varieties of this request (**Table 1**).

B. Know *what you are going to say*. If necessary, write down the key points.
C. *Have the chart*, vital signs, and completed diagnostic results available, since you may not remember all the details.

During the Call

A. Be *direct and concise*. Writing down the points helps beginners do this.
B. *Speak clearly*. Consciously slow your speech if you are anxious or have an unfamiliar accent. (Do not get annoyed if you have to repeat yourself.)
C. Start by saying the *3 "W"s*:
   1. *Who* you are.
   2. *Where* you are calling from.
   3. *What* you want (in a simple declarative statement). This is the *most important part of the call* and, especially when the consultant is involved in other activities or is asleep, indicates the level of alertness they need to handle your call. The options are described below.
D. *Answer any questions*—if you actually know the answer. Don't guess if you don't know, even if you're asked for information that you should have obtained, but didn't.
E. Be certain, in the end, to *get an answer from the consultant* that addresses the reason you called. Responses from the consultants might include:
   1. They will admit the patient. Be certain to ask who will contact the admitting office and whether the consultant, a resident, a hospitalist, or someone else will write the admitting orders. If the patient may need surgery, ask if they should be kept "NPO."
   2. They will see the patient, either immediately or at a specified time. If the time course seems too long for the patient's condition, explain that and try to negotiate a more timely appointment.
   3. The case you are describing is outside their area of expertise. If they don't make it clear, you should ask who they think you should contact.
   4. They are not on call. Hopefully, they can direct you to the person who is on call for their group or that specialty. (Of course, sometimes they actually are on call, but misread the schedule. In those cases, you will simply must call them again.)
   5. They will not see the patient for any of a number of reasons—insurance, too busy, etc. Often, these patients must be referred to an emergency department that has these specialists on call and available.

After the Call

A. *Record* whom you talked with, as well as the time

Table 1. *What You Want* Can Only Take Four Forms

1. *I would like you (the consultant) to come see someone (NOW, or at some point)...*
   a. *...with <presumptive diagnosis or physical findings>, and the patient's condition is <stable, unstable, critical>*. Be specific about any STAT interventions you think are indicated, such as going to the operating room, cath lab, etc.
   OR
   b. *Since your patient is requesting that you see her, can you fit her into your schedule or meet her at the hospital?*
2. *I have a patient to admit to you with <presumptive diagnosis or physical finding>.* Before calling, know whether the patient is "theirs" because of a prior relationship, because they are covering for the patient's physician, or because they are on call for that specialty through the hospital or provider group for "unassigned admissions." Also check to see whether that physician is able to admit the patient to an appropriate hospital, given the patient's medical or psychiatric condition or insurance plan. (Unstable patients can always be admitted by the on call physician through an emergency departments unless that hospital has no ability to care for them. In that case, they must be transferred after stabilization.)
3. *I need to discuss a puzzling* (or not-so-puzzling; if it is their long-term patient, they may have more information than you can get) *case with you.* This verbal cue tells the consultant to pay attention and redirect their attention to you. At night, they will often ask for a moment to fully awaken so that they can process the information. If it is their patient, tell them the patient's name, age, and long-standing main complaint so they have a chance of recalling the person. If it is truly a puzzling case—infectious disease, endocrinology and toxicology consultants frequently get called with these types of cases—have the pertinent information available before calling.
4. *I need to refer a patient to your clinic.* If this call is made after office hours or on weekends, the consultant may not remember the call until the office staff asks about it. If they get a copy of the urgent care chart and it says that you spoke to them and they agreed to see the patient, it also helps jog their memories. Asking about these follow-ups in dicey cases helps patients get to the correct clinics. (What happens when they get there, due to lack of insurance, is variable.) Also, you can e-mail or fax the referral to the consultant's office; have them give you the address/number while you are on the phone with them. Physicians have found (and many patients know) that making such calls often bypasses lengthy waiting lists.[17]

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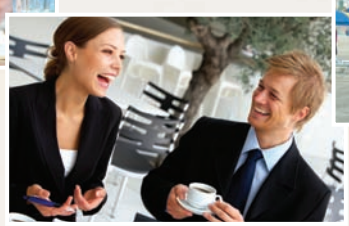


Relaxation

and date. If you must call a number of consultants, which is common when referring to some specialties, list them all.

B. *List the consultant's recommendations*: appointment place and time or place and mode of transfer, as well as anything the consultant suggested be done, such as imaging, laboratory testing, or clinical interventions.

Given a succinct and meaningful interaction, the consultant may simply (1) say that they will see the patient in their office immediately, (2) accept the patient as an admission or say that they will evaluate the patient in the local hospital ED, (3) suggest the best course of action or further specific evaluation so they can recommend the next step, or (4) either accept the patient as a referral to their clinic or tell you why they cannot accept the patient and suggest a more appropriate referral.

Make a list of what the consultant wants done to prepare the patient for a procedure, admission, or further evaluation. Especially if you are requesting a STAT intervention, try to expedite the requested diagnostic tests, medication administrations, or procedures by calling ahead or by sending along the appropriate lab work.

One caveat when calling a teaching institution: If the consultant asks for every lab test to be back and every piece of unnecessary historical information to be gathered, e.g., "standing stool velocity," before he or she will see the patient, you know that you are probably dealing with a junior resident who lacks knowledge and confidence. If the situation is urgent, simply call their attending. If not, live with it. Even in private practice, you occasionally run into this sort of physician.

Discussion

It takes time to develop the rapport necessary for the shorthand conversation portrayed in Case 2. However, using the basic telephone etiquette for urgent care provider-consultant interactions (including consulting with emergency physicians) would have avoided the disastrous results described in Case 1. Consultants say that their trust in a specific caller helps them determine the validity of the information being given and that "junior practitioners may benefit from training in telephone consultations or from guidelines to make the process less haphazard."[17]

The method for telephone interactions with consultants as described above parallels in many respects "contextual" clinical case presentations, i.e., "a flexible means of communication and a method for constructing the details of a case into a diagnostic or therapeutic plan."[18]

This educational model, whether posted as a reminder near the telephones, put on pocket cards or into an electronic file for reference, or taught didactically, is simple to incorporate and leads to our ultimate goal: elegant medical practice and excellent patient care. ■

KEY CLINICAL POINTS

- Physician-to-physician communication, usually by phone, enhances patient care when done properly; handled poorly, however, it can undermine collegial relationships.
- Poor communication may be due to lack of formal training, poor communication skills, and time constraints.
- Calls to consultants may be more effective using the following approach:
  - Before the call, know why you are calling the consultant, what you are going to say, and have the patient's information at hand.
  - During the call, be direct and concise, speak clearly. Start by saying who you are, where you are calling from and what you want. Then answer any questions from the consultant and get an answer for your initial question.
  - After the call, record who you called and what was said, including any consultant recommendation.

REFERENCES

1. Chatterjee A, Lackey SJ. Prospective study of telephone consultation and communication in pediatric infectious diseases. *Pediatr Infect Dis J*. 2001;20(10):968-972.
2. Cotton MF. Telephone calls to an infectious diseases fellow. *Pediatrics*. 1995 May;95(5):753-754.
3. Smego RA, Khakoo RA, Burnside CA, et al. The benefits of telphone-access medical consultation. *J Rural Health*. 1993;9(3):240-245.
4. Abbott KC, Mann S, DeWitt D, et al. Physician-to-physician consultation via electronic mail: the Walter Reed Army Medical Center Ask a Doc system. *Mil Med*. 2002;167(3):200-204.
5. Rushakoff RJ, Woeber KA. Evaluation of a "formal" endocrinology curbside consult service: advice by means of internet, fax, and telephone. *Endocr Pract*. 2003;9(2):124-127.
6. Association of American Medical Colleges: *Contemporary Issues in Medicine: Communication in Medicine*. Washington, DC:AAMC, p 17, 1999.
7. Accreditation Council for Graduate Medical Education: *General Requirements*: 3.E.3 Interpersonal skills and communication. http://www.acgme.org/RRC_PreDocs/Quad101400.pdf <Accessed 10-14-04>.
8. Website: http://www.acgme.org.
9. Chapman DM, Hayden S, Sanders AB, et al. Integrating the Accreditation Council for Graduate Medical Education Core competencies into the model of the clinical practice of emergency medicine. *Ann Emerg Med*. 2004 Jun;43(6):756-769.
10. Hockberger RS, Binder LS, Graber MA, et al. The model of the clinical practice of emergency medicine. *Ann Emerg Med*. 2001;37:745-770.
11. Williams PT, Peet G. Differences in the value of clinical information: Referring physicians versus consulting specialists. *J Amer Board Fam Prac*. 1994;7:292-302.
12. Lee T, Pappius E, Goldman L. Impact of inter-physician communication on the effectiveness of medical consultations. *Am J Med*. 1983;74:106-112.
13. Bourguet C, Gilchrist V, McCord G. The consultation and referral process. A report from NEON. *J Fam Prac*. 1998;46:47-53.
14. Epstein R. Communication between primary care physicians and consultants. *Arch Fam Med*. 1995;4:403-409.
15. Saunders T. Consultation-referral among physicians: Practice and process. *J Fam Prac*. 1978;6:123-128.
16. Larsen J-H, Risôr O. Telephone consultations at the emergency service, Copenhagen County: analysis of doctor-patient communication patterns. *Fam Prac*. 1997; 14(5):387-393.
17. Hollins J, Veitch C, Hays R. Interpractitioner communication: telephone consultations between rural general practitioners and specialists. *Aust J Rural Health*. 2000; 8:227-231.
18. Haber RJ, Lingard LA. Learning oral presentation skills: a rhetorical analysis with pedagogical and professional implications. *J Gen Intern Med*. 2001 May;16(5): 308-314.

INSIGHTS IN IMAGES

CLINICAL CHALLENGE: CASE 1

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

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

Figure 1

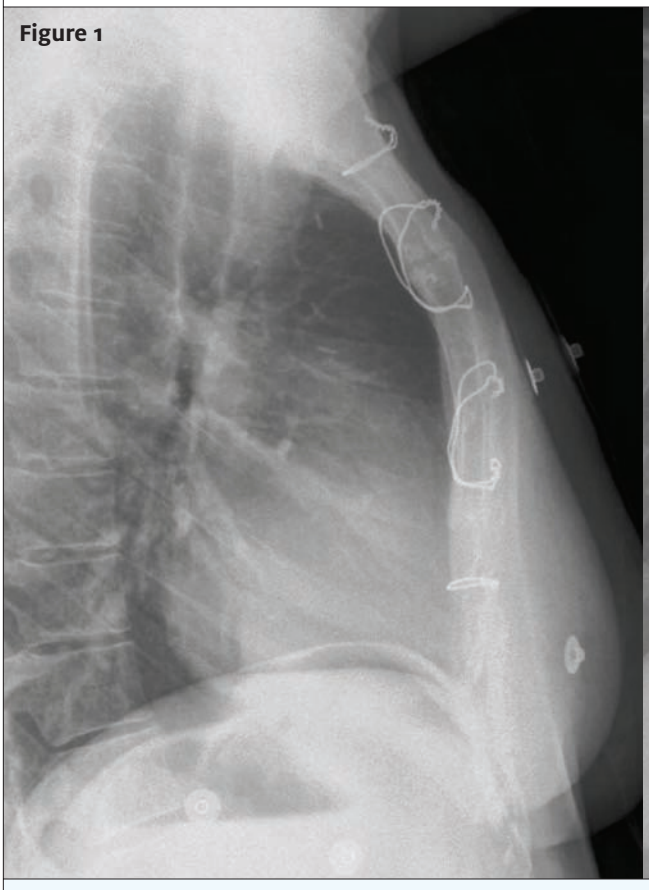
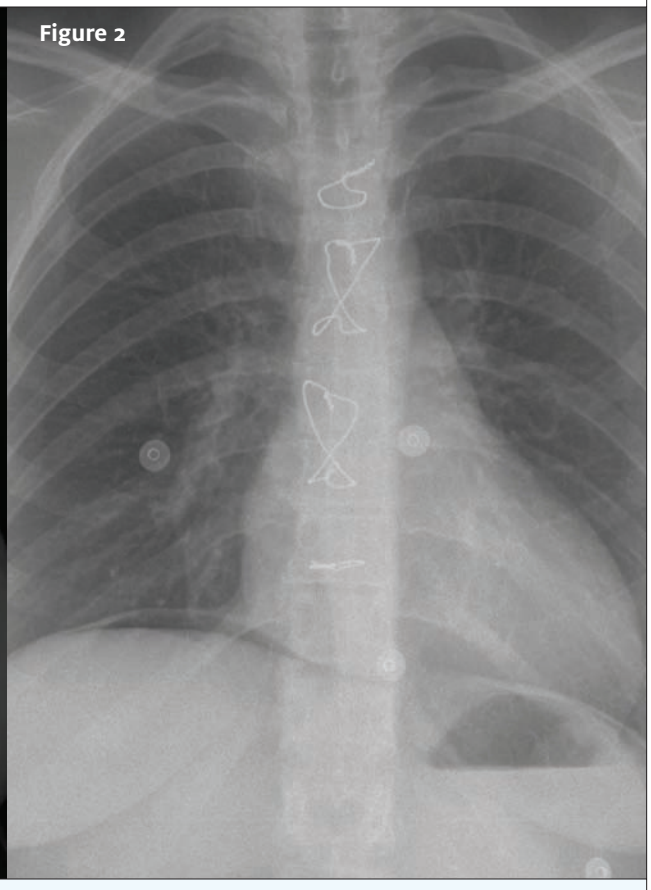


Figure 2



The patient is a healthy 38-year-old who presents with progressive abdominal pain. There is no fever, vomiting, or diarrhea.

Upon examination, you find:

- No peritoneal signs
- Pulse is 55
- Blood pressure is 118/50

The only remarkable finding when the history is taken is that the patient had corrective heart surgery as a child.

View the x-rays taken (**Figure 1** and **Figure 2**) and consider what your next steps would be. Resolution of the case is described on the next page.

Figure 1

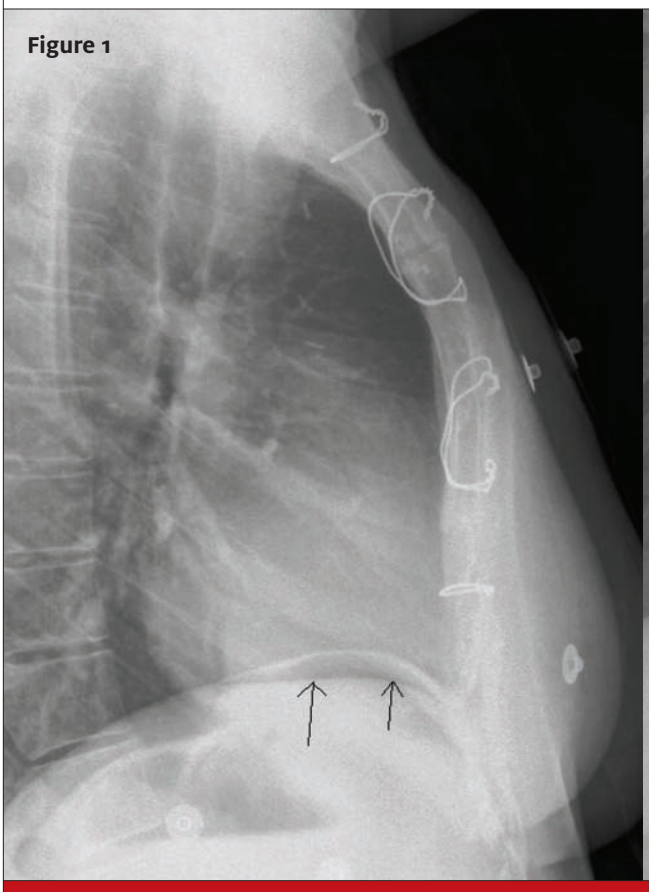
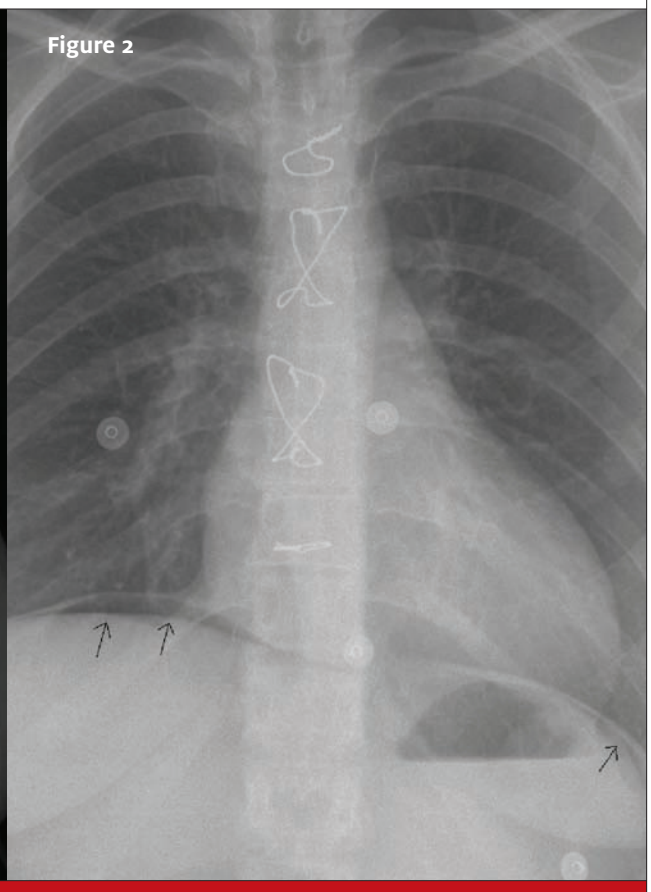


Figure 2



THE RESOLUTION

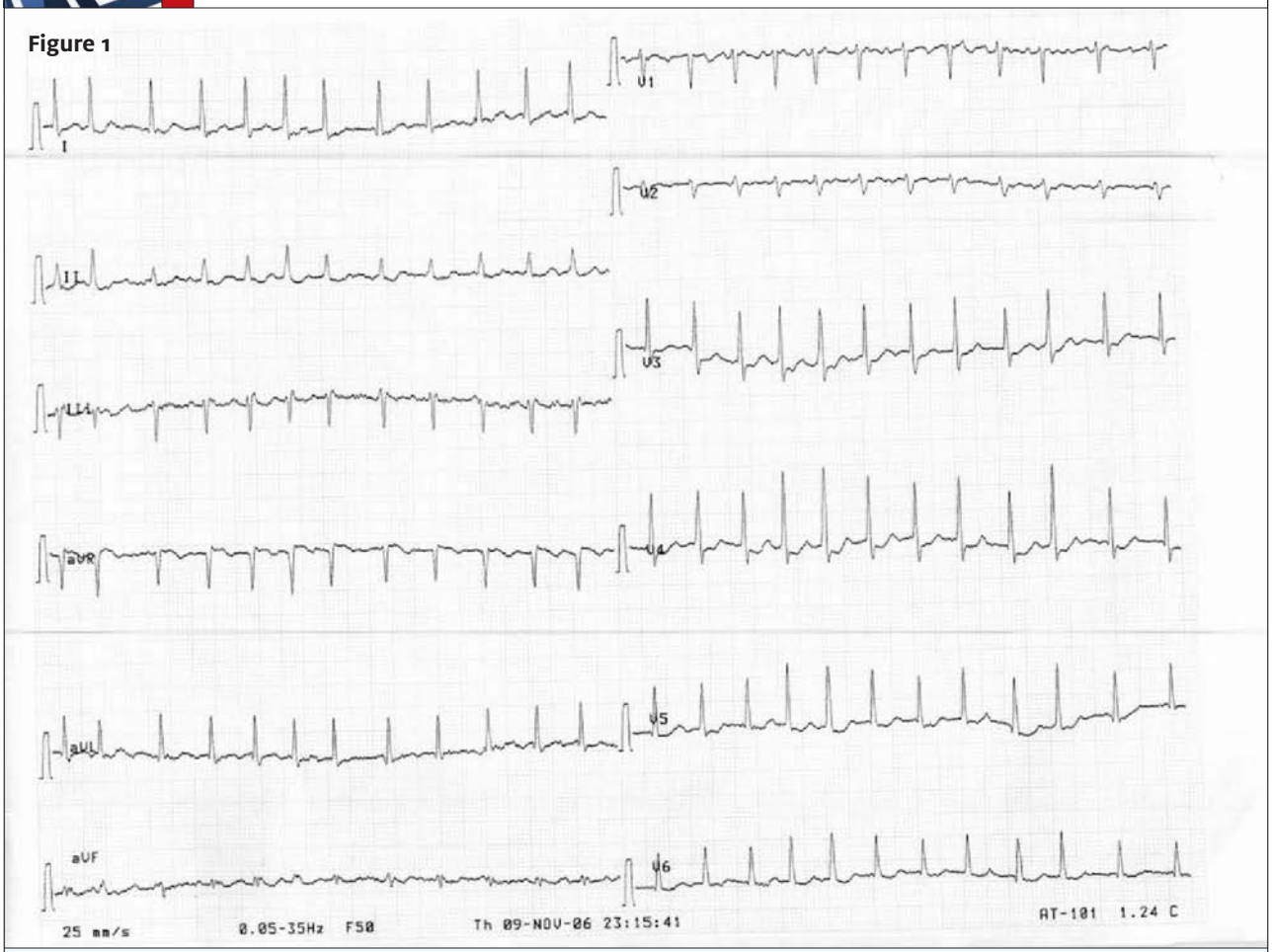
The patient has free air under the diaphragm. Given the history, the suspicion was that this was from a perforation secondary to peptic ulcer disease. The patient was referred to hospital.

Acknowledgment: Case presented by Dr. Ohad Sheffi, who treated and referred the patient described.

INSIGHTS IN IMAGES

CLINICAL CHALLENGE: CASE 2

Figure 1

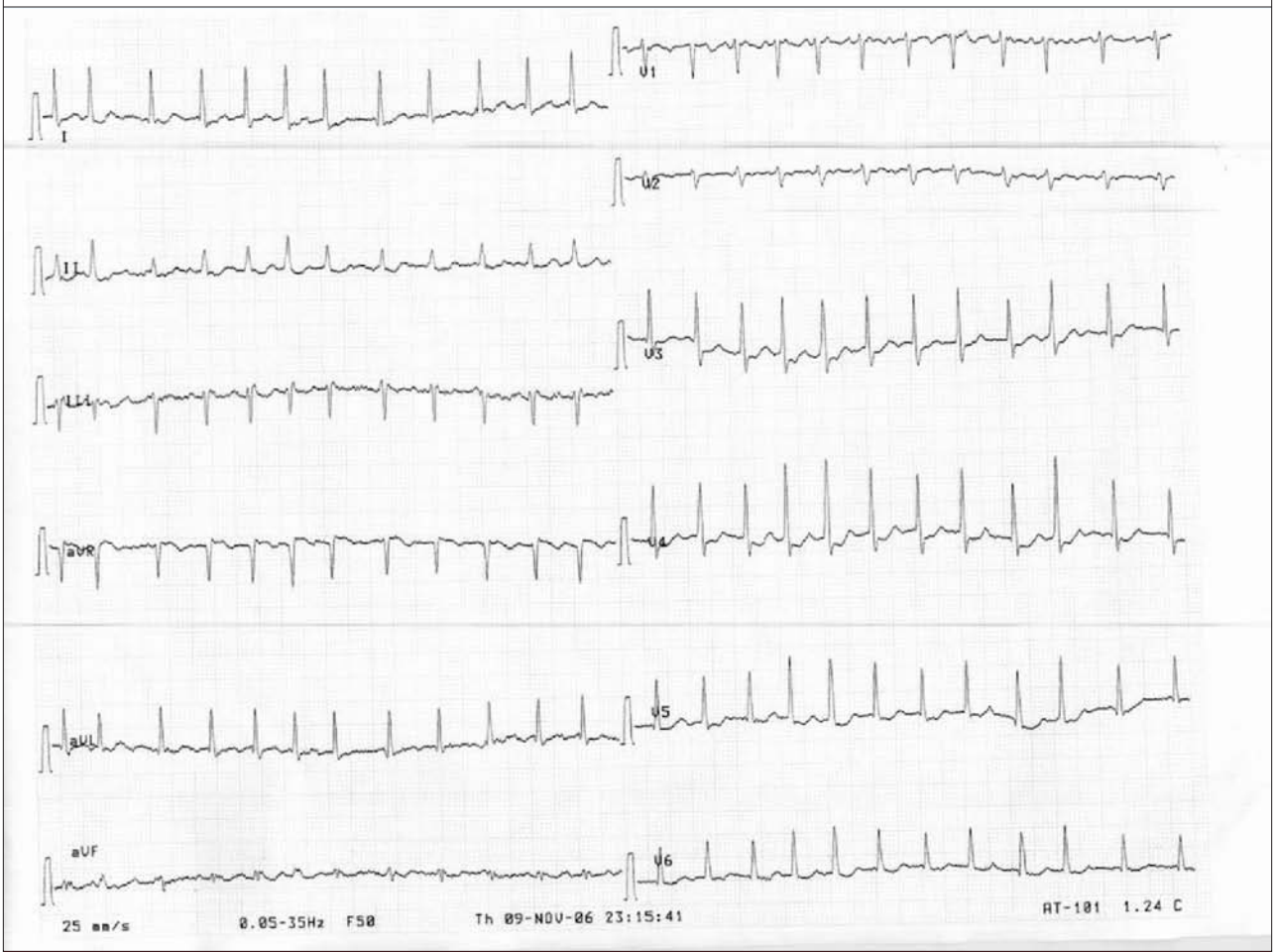


A 78-year-old woman presents to your urgent care clinic with new onset palpitations that began a few hours before presentation.

Upon examination, you find:

- Pulse is 123
- Blood pressure is 152/83
- The only existing issue she admits is hypertension, for which she is taking thiazides as directed.

Consider **Figure 1**, above, and what your possible diagnosis might be, based on the evidence available. Resolution of the case is on the next page.



THE RESOLUTION

The patient is experiencing irregular supraventricular rhythm, with a variable rate 125-175; most probably, atrial fibrillation (though it could be atrial flutter with variable block). The ST changes seen are most probably rate related.

However, if the clinical picture is highly suggestive, ischemia must be ruled out

Acknowledgment: Drs. Todd Zalut and Michale Baum presented this case and referred the patient.

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On Antibiotic-Seeking, Predicting Prognosis in Rhinosinusitis and Mortality in Head Injuries, and When to Use Antibiotics in Conjunctivitis

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.

Are Sore Throat Patients Who Hope for Antibiotics Actually Asking for Pain Relief?

Citation: van Driel ML, De Sutter A, Deveugele M, et al. *Ann Fam Med*. 2006;4:484-485.
URL: *http://www.annfammed.org/cgi/content/full/4/6/494*
Key point: The desire for pain relief is a strong predictor of the hope to receive a prescription for antibiotics.

Antibiotics are still overprescribed for self-limiting upper respiratory tract infections such as acute sore throat; physicians point to patients' desire for antibiotics as a driving force. The authors studied patients' concerns when visiting their family physician for acute sore throat, more specifically the importance they attach to antibiotic treatment and pain relief.

Family physicians in six peer groups in Belgium participated in an observational postvisit questionnaire survey. Patients aged 12 years and older making an office visit for acute sore throat were invited to indicate the importance of different reasons for the visit. Sixty-eight family physicians provided data from 298 patients.

The three most frequently endorsed reasons for visiting the physician were:

- examination to establish the cause of the symptoms
- pain relief
- information on the course of the disease.

Hopes for an antibiotic ranked 11th of 13 items. Patients who considered antibiotics "very/rather important" valued pain relief significantly more than patients who considered them "little/not important" ($P<.001$). Patients who hoped for antibiotics felt more unwell ($P<.001$), had more faith in antibiotics to speed recovery ($P<.001$), and were less convinced that sore throat was self-limiting ($P<.012$). The desire for pain relief is a strong predictor of the hope to receive a prescription for antibiotics.

This study suggests that patients with acute sore throat and who hope for antibiotics may in fact want treatment for pain.

Comment: This raises the question of whether a physician could "nullify" the request for antibiotics by simply saying "antibiotics do not stop the pain. NSAIDs do!" Of course, what this paper also shows is the mixed messages that are shared by physician and patient. Until we understand why a patient has come for care, it will be much harder to treat the real problem. ■

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

Predicting Prognosis and Effect of Antibiotic Treatment in Rhinosinusitis

Citation: De Sutter A, Lemiengre M, Van Maele G, et al. *Ann Fam Med*. 2006;4:486-493.
URL: *http://www.annfammed.org/cgi/reprint/4/6/486*

Key point: Antibiotics don't affect the course of rhinosinusitis and abnormal radiographs don't provide any information about its prognosis.

Researchers performed a secondary analysis of data from a randomized, placebo-controlled trial of amoxicillin in patients who were at least 12-years-old and presented to family physicians with respiratory tract infections and purulent rhinorrhea. For this analysis, they included 300 patients who additionally had at least one symptom indicating acute rhinosinusitis.

Patients' general feeling of illness and reduced productivity at visit were independently associated with a longer course of illness; however, neither abnormal radiographs nor typical sinusitis signs and symptoms were of prognostic value. Amoxicillin failed to affect patients' prognosis, regardless of their baseline symptoms.

"The best policy for patients with suspected rhinosinusitis—but without signs of complications or severe infection (high fever and bad pain)—is to wait for spontaneous recovery," the authors concluded. ■

Early Prediction of Mortality in Isolated Head Injury Patients: A New Predictive Model

Citation: Demetriades D, Kuncir E, Brown CV, et al. *J Trauma*. 2006:61:868-872.

URL: *http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=PubMed&list_uids=17033553&dopt=Abstract*

Key point: The proposed model has better predictive power than other extensively used scoring systems.

The purpose of this study was to construct a predictive model of survival in isolated head injury patients on the basis of easily available parameters that are independent risk factors for survival outcome. This was a trauma registry-based study of head injury patients who had no other major extracranial injuries and who were not hypotensive at admission. The study included 7,191 patients with head trauma.

The overall correct classification rate of the proposed predictive model was 94.2% as compared with 89.0% of the admission GCS score ($p<0.05$) and 92.8% of the head AIS ($p<0.05$). The correct classification rate of the predictive model developed for the severe head trauma (GCS score 4-8) patients was 79.9%, as compared with 72.6% using the admission GCS score alone or 75.1% ($p<0.05$). A one-page, easy-to-use table summarizing the predicted mortality on the basis of GCS score, head AIS, mechanism of injury, and age was developed.

The proposed model has a significantly better predictive power, especially in severe head trauma, than the extensively used GCS and head AIS. A simple table on the probability of death of a particular patient based on admission GCS score, head AIS, mechanism of injury, and age of patient can provide instant information. ■

Antibiotics for Conjunctivitis: OK to Delay?

Review by Kristi L. Koenig, MD, FACEP

URL: *http://emergency-medicine.jwatch.org/cgi/content/citation/2006/901/4*

Citation: Everitt HA, Little PS, Smith DW. A randomized controlled trial of management strategies for acute infective conjunctivitis in general practice. *BMJ*. 2006;333:321-324.

Citation: Rietveld RP, Bindels PJ, ter Riet G, et al. Antibiotics for upper respiratory tract infections and conjunctivitis in primary care. *BMJ*. 2006;333:311-312.

Key point: Benefit from antibiotics is questionable, at best.

Topical antibiotics are prescribed commonly for acute infective conjunctivitis, but are they really necessary? Researchers randomized a convenience sample of 307 patients aged 1 year or older from 30 general practices to receive one of three treatments: immediate antibiotics (chloramphenicol drops), delayed antibiotics (prescription for chloramphenicol drops provided after three days), or no antibiotics. Patients were also randomized to receive an informational leaflet, or not, and then further randomized to provide an eye swab, or not.

Antibiotics were actually used by 99% of the immediate-antibiotic group, 53% of the delayed-antibiotic group, and 30% of controls. Severity of symptoms one to three days after presentation was similar among the three treatment groups. However, duration of moderate symptoms was shorter in the immediate- and delayed-antibiotic groups compared with controls (3.3 and 3.9 vs. 4.8 days, respectively). Patients in the immediate-antibiotic group were more likely than controls to believe that antibiotics were effective and to state that they would seek medical care again for a new episode. Patients in the delayed-antibiotic group were less likely than controls to return to the clinic within two weeks (odds ratio, 0.3). An informational leaflet or eye swab had no significant effect on any outcomes, but satisfaction was greater among patients who received leaflets.

An accompanying editorial reminds us of the potentially harmful effects (such as drug resistance and adverse events) of prescribing antibiotics that might not be needed for minor self-limiting illnesses.

Comment: This study of a management approach for a disease that is often self-limiting was too small to detect a difference in complication rates among treatment groups. In addition, it is very unlikely that antibiotics initiated on day 3 were responsible for the delayed-treatment group's achieving resolution similar to that in the early-treatment group. Most conjunctivitis is viral, and even topical antibiotics carry some risk to the individual (e.g., sensitization) and population (e.g., resistance). These data should cause us to reconsider whether antibiotics are truly indicated for this common, self-limiting disease. ■

How to 'De-Commoditize' Your Urgent Care Practice

KEVIN J. RALOFSKY, MBA

If your practice is in its first year or two of operations, it is easy to stay on top of what your patients want, the quality of their care, and the customer service they are receiving. But as your practice grows, patient counts increase, and you add more corporate clients to your occupational medicine business, you also add links to the customer service and quality care chain.

Increasing the number of care providers, nurses, office support team members, and back-office operations staff creates the potential for growth. However, this growth can have a detrimental effect on your practice; somewhere along the way, the opportunity to deliver average, mundane, monotonous—or even poor—quality care and customer service will rear its ugly head.

How can you compete and succeed if your patients feel that you offer the *same* quality of care and the *same* long wait times as other providers, in addition to a difficult phone menu to navigate and even good, yet impersonal, customer service?

Perception Plays a Large Role in Quality Care

It is unfortunate that even though you commit many years to education and training as a provider, your patients are unable to gauge the actual quality of care that you provide. As a matter of fact, most patients will judge the quality of the medical care they receive *from a customer service perspective*, based on how they or their family members were treated during the visit.

In working with my clients over the past several years, I have paid close attention to the delivery of quality customer service. In fact, I believe that this issue is so important that I have conducted studies to quantify this unfair phenomenon.

In part of my research, I wanted to find out how customer service and "personalizing" the visit would play a role in the perception of a patient's time in the waiting room.

Kevin J. Ralofsky is president of MedCapital, Inc., a consulting firm focusing on strategic growth and revenue generation and specializing in the urgent care industry. He can be reached at (330) 304-5680 or by email at *kralofsky@med-capital.com*.

Two groups were evaluated—a control group and a test group. Each group's patients waited exactly 15 minutes in the waiting room, then were brought to an exam room by a nurse to have vital signs taken and the chief complaint addressed.

For the control group, the nurse only engaged in conversation pertaining to the visit. For the test group, the nurse engaged in additional conversation addressing personal questions, such as "How was your holiday?", "I really like your blouse", "How old are your children? They are so cute!"

The nurse saw each patient in both groups for the same amount of time. In addition, all patients waited five minutes for the physician to come into the exam room after the nurse left. Again, the control group was treated clinically only and not engaged in any personal conversation. For the test group, the physician also engaged in personal conversation and addressed family members present. The physician spent approximately the same amount of time with each patient in each group.

Remember, both groups had the same wait times and approximately the same amount of time with the nurse and the physician.

When we asked the patients about their visit, though, the control group reported waiting 23 minutes while the patients in the test group said they waited 11 minutes—an average of 12 minutes less in the waiting room.

Recognizing that the patient's perception of the visit is colored by such non-clinical factors is an important realization. This means you can delegate important functions that might add up to greater patient satisfaction, while freeing yourself to concentrate on providing medical care.

Draft a "Quarterback"

Physician managers tend to take on more than they can handle in business. It is imperative that minor tasks be delegated to those team members who can be trusted to see them through. To make sure this gets done on a consistent basis, you will want to select a "quarterback" to lead your office through its daily operations.

Your quarterback could be your office manager, billing manager, or any person that is entrenched in the daily grind of your practice and who has direct contact with your patients.

However, I strongly suggest that your quarterback be the employee who will check your patients in and out. If your office flow calls for these tasks to be done by two separate people, then a co-quarterback team of two individuals.

Personal Service and Patient Perception

	Actual wait time	Self-reported wait time (average)
Control group (clinical communication only)	15 minutes	23 minutes
Test group (personal communication)	15 minutes	11 minutes
Difference	0 minutes	12 minutes

A quarterback is a team member who exudes exemplary customer service, has unparalleled empathy for your patients and—this is the key—knows exactly what is going on with patient flow and with customer satisfaction at all times.

Your quarterback should be the first and last person that a patient sees during the visit. As illustrated previously, customer service and personalizing the office visit play a large role in a patient's perception of the level of quality care that they receive. With a strong quarterback, you have the opportunity to reinforce your practice's dedication to customer service.

There are several simple things your quarterback can do to ensure that a patient's visit is a success:

- Say "thank you" when the patient arrives and before they leave the office.
- Come out to the waiting room once every 30 minutes and ask patients if they need assistance with anything. Assure them that the staff and the physician know they are waiting, and that they will be seen soon.
- Know where *every* patient is in the triage process.
- Use phrases like "How can I help?", "I can solve that problem", "I don't know but I will find out", "I will take responsibility", "I will keep you updated", and "I appreciate you coming in today."

Other Ways to De-Commoditize Your Practice

Remember, patients cannot determine the level of quality care that you provide, absent the blatant disregard for medical care that results in a possible malpractice claim. The goal is to make your practice stand out from all of the others so that patients are more likely to frequent your facility than others. They may even prefer your practice to their primary care physician's office if their experience is positive enough.

In addition to selecting and empowering your quarterback, there are some organizational things you can do:

- *Offer fast track rooms for certain services to loosen the bottleneck*. If you offer occupational medicine services to corporate clients, dedicate a room (or rooms) solely to workplace injuries, physicals, drug screens, and other forms of tests. Often, a physician will not even need to see a patient who has come in only for a drug screen or a physical. And injured employees are still on the clock. Your corporate clients will see this as an obvious benefit, as employees will get back to work much more quickly and the employer will save money. In addition, this loosens the bottleneck for the sick patients waiting to be seen by the physician.
- *Offer various stages of waiting*. Often, if a patient is moving through the triage process at different stages, he will feel like progress is taking place. If there is an open exam room but the physician or nurse cannot see a patient for 10 more minutes, I suggest moving the patient to that exam room. The quarterback can then check on him periodically until he is treated. The patient feels one step closer to seeing the physician and having his problem addressed, and can't hear the negative comments made by patients who are still in the waiting room.
- *Offer open houses and education seminars*. An open house is not just for a grand opening anymore. Patients need to feel welcome and comfortable before they will refer your practice to a family member or friend. Holding monthly open houses or educational seminars at the facility is a great way to meet new patients, showcase your facility, and advertise your dedication to customer service.
- *Personal callbacks breed success for the future*. The practice of medicine is getting impersonal, with automated callbacks, patient scheduling reminder systems, e-mails and voicemails. To make a lasting impression, make it a point to call back every new patient after his or her first visit. Thank them for coming, and ask them how they are feeling. This is most impactful if it comes from the treating physician, but if that is not possible then the treating nurse or the quarterback will still make a lasting impression simply by picking up the phone. If patients are truly satisfied with the level of care and service your clinic provided, you can even go one step further and ask them to recommend your facility to a family member or friend.

"Personal service" applies to corporate clients, too. Physicians should be calling occupational medicine contacts on every injury's first visit before the patient leaves the office.

Continued on page 33

What to Do When You Get Named in a Malpractice Suit

JOHN SHUFELDT, MD, JD, MBA, FACEP

Your front office receptionist informs you that there is a man at the door who says he is a process server, and that he wants you to sign for a registered letter. Your first thought, of course, is to run out the back door of your office or to simply feign a stroke.

Instead, common sense prevails and you sign for the letter informing you that you are a named defendant in a malpractice suit. What do you do?

If your answer is to move all of your assets into your spouse's name, think again.

Many physicians are named in a malpractice suit at least one time in their professional career. Consequently, the odds are against your being able to dodge the bullet forever. However, in the end, only 20% to 40% of malpractice suits filed against physicians end up with a payout to either the plaintiff or their attorney.

You can even improve upon those odds if you follow a few simple steps.

Prior to actually being served, many patients give the physician a "heads up" that their care did not meet their expectations. These "shots over the transom" are a gift. Take time to talk with the patient, address their concerns, and write off a bill if necessary to make them happy.

Clearly, some patients enter the relationship with expectations which are off the chart, and nothing a provider can do will make the patient happy. As mentioned in a previous article, these are the patients that belong in your competitors' clinics. Dismiss them from your practice as soon as practicable.

If, however, you missed the initial signs and symptoms of the "impossible to please" patient, deal with them in the most professional and polite manner possible and then appropriately dismiss them after the course of their illness.

John Shufeldt is chief executive officer of NextCare, Inc. and sits on the Editorial Board of ***JUCM*** *The Journal of Urgent Care Medicine.*

Sharing the Bad News

When should you report patient complaints to your insurer? Clearly, a physician does not need to report every little issue that a patient complains about. If you are unsure, do *not* talk with a colleague, since that conversation may be admissible as evidence.

The safer course of action is to seek the guidance of an experienced medical malpractice attorney. If still in doubt, the default position is to simply report the incident to your carrier. If the patient has taken the time to write you or come in separate from their appointment to discuss their concerns, you should report.

Reporting the potential claims will not increase your malpractice rates. Insurers understand that medicine is a risky business and that not everyone will always have a good outcome. Often times, the insurer along with consul can mitigate the damages of a bad outcome case if it was reported early enough.

Once you are actually served, ignoring the summons won't make it go away. After you receive a summons, you need to report it to your insurer immediately. In fact, if you have not read your malpractice policy, you should do so now since many policies have very clear guidelines on reporting.

Also, once you have been named, you should not communicate directly with the patient unless they are being seen for a medical condition. *Under no circumstance should you attempt to call or contact the patient regarding the litigation.* There is absolutely no upside to communicating with the patient about their claim.

Another important caveat: Do not in any way alter the medical record. This means do not cross something out, "lose" a page, remove a lab test or a consult, etc. If you must add something to the record, appropriately date and time the addendum. I knew a physician who dictated an outrageously defensive operative report 10 days after the surgery and three days after the patient died as if he had just walked right out of the operating room. He neglected to realize that all dictated notes have a "date dictated" and "date transcribed" annotation at the end of the dictation. Needless to say, he paid dearly for that transgression.

"Insurers are experts at dealing with malpractice claims; their resources should be appropriately utilized."

Aiding in Your Own Defense

Once you report the claim to your insurer, make sure you do your best to assist the claims representative. Your carrier needs your expertise in defending the cause of action. They will need your billing history, medical records, every communication about the patient, and any authoritative references which support your treatment decisions.

Once you are named, you become a member of the defense team along with your claims representative, legal consul, and expert witnesses. In order for your defense team to work to its optimum level, all members of the team need to be working in concert with the common goal of mitigating your professional and financial damages.

Many providers once named will take the "misery loves company" approach and look for other providers and/or institutions to blame. The result of this is that now someone else will be named and will often point the finger right back at them. Plaintiffs' attorneys love when professionals point fingers at one another. Even if someone else has some responsibility in the patient's outcome, the typical rebuttal is that the other named defendants should have identified the error and intervened on the patient's behalf. When providers engage in finger pointing, the usual end result is that everyone goes down together.

As providers, we pay a significant price for malpractice insurance. Unfortunately, many times we do not take full advantage of the coverage we purchase. Nor do we take the time to read and understand the malpractice policy, its limits, and our responsibilities. Insurers are experts at dealing with malpractice claims, and their resources and expertise should be appropriately utilized when a claim ensues or a potential claim is uncovered.

Finally, medical malpractice insurance is a cost of doing business, as is the trauma of being named in a suit. I have witnessed a few providers who have been emotionally ruined by going through the process. Their reaction took a very large toll on their family, their practice, and their mental health.

If you are named in a malpractice suit, it is not the end of the world; the odds are on your side, and as a long as you have done what you believed was in the best interest of the patient, chances are you will be exonerated. ■

Continued from page 31

This does several things:

- It establishes that you are finished treating the employee and they can expect them back on the job shortly.
- You can discuss the protocol for return to work and any work restrictions that the employee may have.
- You can establish what is expected for the remainder of the treatment.
- You drive home the fact that your corporate clients are important to your practice and you appreciate their business.

Practices I have worked with in the past have made a lasting impression by offering a few options for "waiting." To better serve your sick patients and occupational medicine clients, as well as those family members who accompany them to your clinic, offer three areas in the waiting room separated by either partition walls or even use separate rooms if you have enough space: 1) waiting room for truly sick patients; 2) waiting room for healthy patients or family members or friends who came with a sick patient; 3) waiting room for your occupational medicine patients (whose clothes often are dirty from the machine shop or whose shoes may be soaked with oil from the shop floor).

In addition, investing $300 in a television and game system or a computer dedicated to the children's area can make a lasting impression. If you do not have enough space for three distinct waiting areas, make your best effort to segregate the area as much as possible.

There are many ideas that you can implement to decommoditize your practice. Find out what other practices and facilities are doing to differentiate themselves from the competition. Ask your current patients what it is that makes your practice stand out. Expand on those ideas and cultivate your strengths. However, choose only a few that you know you will do best and stick to those. Track your results by asking patients what they liked best about the office visit.

If you focus on these ideas and concepts, you will begin to see your business expand. Most importantly, you will see the gap between your practice and those you compete with start to widen. ■

TAKE-HOME POINTS

- Most patients judge the quality of care they receive from a customer service perspective.
- Delegate minor tasks to trusted team members.
- Select a "quarterback" to lead your office through daily operations.
- Consider hosting an open house or a series of seminars for the community.
- Personal follow-up calls after a patient visit make a lasting impression. (That goes for corporate clients, too.)

CODING Q&A

How to Define a Type B ED—and Other Vexing Questions

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, he addresses a potpourri of issues raised by urgent care practitioners.

Q. A consultant tells us that we have to use the new codes for type B emergency departments. We are owned by the hospital, but are off campus and do not advertise ourselves to be an emergency department. Are we a type B emergency department?

A. There has been a lot of confusion about type B emergency departments this year. Some consultants have been telling urgent care administrators that they are a hospital-owned urgent care center, so they are a type B emergency department. Simply being hospital owned, however, is not adequate to meet the specific criteria outlined by the Centers for Medicare & Medicaid Services (CMS).

To be a type B emergency department, your center must meet one of the following criteria:

- It is licensed by the state in which it is located under applicable state law as an emergency room or emergency department. *[Unless your center is licensed as an emergency department, this does not apply.]*
- It is held out to the public by name, posted signs, advertising, or other means as a place that provides care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment. *[Rarely does an urgent care clinic hold itself out to the public as treating "emergency conditions." Rather, almost all urgent care centers tell the public specifically that their centers are not appropriate for evaluating or treating true emergency conditions. Instead, most urgent care centers tell the public to go to a hospital emergency department or to call 911 if the problem is thought to be a true emergency.]*
- During the calendar year immediately preceding the calendar year in which a determination under this section is being made based on a representative sample of patient visits that occurred, at least one-third of all outpatient visits to the urgent care center are for the treatment of emergency medical conditions on an urgent basis without requiring a previously scheduled appointment. *[Very, very few urgent care centers treat over one-third of their patients for true emergency conditions. Some hospital emergency departments may not even meet this criterion.]*

Very few urgent care centers will meet any of the above three requirements, and thus they should not be classified as type B emergency departments.

Some confusion may arise from the third criterion. There are three parts, however, to this final criterion, and your center must meet the definition in *all three parts* (not just one or two parts) to qualify as a type B emergency department. So, if we evaluate all three parts, the question is this: Are over 1/3 of the visits to your center:

- on an urgent basis
- without appointment
- *and* for treating emergency medical conditions?

Many urgent care centers may answer "yes" to the first two components, but for the majority of true urgent care centers, the answer to the last question is almost always "no." Hence, they do not qualify as type B emergency departments.

Q. We frequently remove cerumen from the ears of patients in our urgent care center. We use different methods for removing the cerumen, including irriga-

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*.

tion, spoon, loop, or forceps.

When can I use CPT code 69210, "Removal impacted cerumen (separate procedure), one or both ears"?

A. CMS limits the use of 69210 for cerumen removal to visits that meet *all* of the following criteria:

- Cerumen removal is the only reason for the visit.
- Cerumen removal is personally performed by a physician or midlevel provider.
- The patient is suffering symptoms from excess cerumen.
- Removal requires more than drops, cotton swabs, and cerumen spoon.
- Chart documentation shows that the procedure required significant time and effort.

CPT, however, does not specify what method is used for cerumen removal, and many payors use different guidelines for coding for cerumen removal. You may want to check with individual payors to determine their policies for using this code.

Q. **What code should I use for destruction of plantar warts or molluscum contagiosum?**

A. The codes for lesion destruction have been changed for 2007. You should now use CPT codes 17110 and 17111 for destruction of common or plantar warts. These codes—17110 and 17111—have been revised to include destruction of benign lesions other than skin tags or cutaneous vascular lesions. Codes 17000 and 17003 now exclude destruction of benign lesions.

Q. **How should I code for a fracture of the distil radius that includes a fracture of the ulnar styloid?**

A. A 2007 revision to CPT code 25600 for closed treatment of a distal radial fracture now states that this code "includes closed treatment of fracture of ulnar styloid, when performed." Thus, both fractures are bundled into the same code (25600).

Q. **Allergists sometimes send patients to us for allergy shots. If we give two allergy shots to a patient on the same day, should I add code 95117 to 95115 or should I use just 95117?**

A. Use CPT code 95115 for a single injection on a given date. If you administer more than one allergy injection (two, three, or even 10 allergy injections) on a single date, then code only a single code 95117.

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.

Please e-mail your idea to
JUCM Editor-in-Chief
Lee Resnick, MD at
editor@jucm.com.

He will be happy to discuss it with you.

Leveraging Existing Relationships to Generate More Business

FRANK H. LEONE, MBA, MPH

Urgent care clinic operators tend to think of increasing employer-generated volume primarily in terms of new prospects; that is, they tend to believe that growth is attained primarily by expanding their client base.

But in many cases, there is as much—if not more—opportunity inherent in selling additional services to existing clients. And "cross selling" to existing clients is just one of many potential advantages that your clinic can accrue by leveraging the positive relationships that you are likely to have with many existing employer clients.

Before trying to figure out what else you can sell those clients, though, you must first ask: Are they happy with the relationship and with the services we are already providing?

It is risky business to assume that a given employer client is happy with your clinic's services simply because you have not heard anything to the contrary. Accordingly, you should seek multiple opportunities to continuously assess client satisfaction.

For example, you can place quarterly "check-in" calls to high-volume clients or send an annual questionnaire to all employer clients.

The long-run viability of incorporating occupational health services into an urgent care clinic's service mix lays in its ability to expand the scope of services for employer clients. If the clinic focuses entirely on injury management, then the occupational health component of the business is likely to perish, over time. Thus, developing and marketing additional services to your existing customer base becomes a central survival strategy.

You have several advantages in dealing with an existing client, compared with the challenge of landing a new one:

- You (and/or your clinic) know the client and—presumably—have generated a foundation of trust. Since attaining trust and credibility is never an easy task, a large hurdle has already been successfully navigated.
- The client is a previous buyer/user of your clinic's services. They have used you in the past; they know that, and so do you.
- Presumably, you know the client's business and are well positioned to understand how a proposed new service will fit into the larger picture.

Building on these positives, you now need to leverage these relationships by emphasizing the inherent merit of an integrated approach to each employer client's healthcare needs. Consider the following:

"Our foremost goal is to make the greatest possible impact—both health status-wise and cost management-wise—at each client's workplaces. We recognize that the best way to make such an impact is through carefully integrated delivery of services. To date, we have provided [specific service(s)] to your company. Now that we know your company better, we realize that by also offering [specific new services], the impact to your workplace health status, and to your bottom line, would be even more dramatic."

Generating Leverage on the Marketing Side

Building on existing relationships does not end on the sales side. Let's look at some examples on the broader marketing side:

- *Employers as references*

  Three hard rules apply:
  - Find a mechanism by which to ask every employer client to serve as a reference and build up as long a list as possible.
  - Overwhelm reference readers with volume. If 100 employers are willing to serve as a reference for your clinic, list them all; it provides exceptional credibility.
  - Provide as much information about each reference as

Frank Leone is president and CEO of RYAN Associates and executive director of the National Association of Occupational Health Professionals. Mr. Leone is the author of numerous sales and marketing texts and periodicals, and has considerable experience training medical professionals on sales and marketing techniques. E-mail him at *fleone@naohp.com*.

Career Opportunities

V.P. OF URGENT CARE SERVICES – V.P. will be responsible for the establishment of centers and overall operations for a new multi-state urgent Care/Diagnostic Imaging Center Company. Base salary, bonuses and great stock options for the right individual. Previous UCC administrative experience preferably in "start-up" centers is required. Prefer RN, PA or NP but others con- sidered depending on experience. Fax CV and salary requirements to: Urgent Care Centers, Inc. (478) 275-9874. All qualified applicants will be contacted.

Mt. West Health Center, P.A. is currently seeking physicians to join practices in El Paso, Texas for Urgent Care Center. Excellent opportunity to work with a large, established private family/urgent care practice in an autonomous manner with other physicians and physician assistants. We offer a competitive salary and benefits package. Please contact: Brisa Newberry, MBA. Phone: (915) 217-2809, Email: brisabn@gmail.com, Fax: (915) 850-0546.

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Career Opportunities

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makes sense (e.g., name, title, company, phone, email address).

- *Employer testimonials*
  Employer testimonials enhance your marketing effort with the glow of others' words rather than transparent, self-serving boasts. Systematically request testimonials (e.g., through an annual employer questionnaire), then archive quotes as applicable for appropriate audiences.
- *Direct employer referrals*
  Employers know other employers. There is nothing wrong with asking a happy client to make a call (or send an e-mail) to one or more selected colleagues on your clinic's behalf.
- *Referring physicians and payors*
  Both groups may offer multiple contacts and, in the case of payors, numerous clients. Once a good relationship has been established, there is nothing wrong in asking for a referral in your behalf.
- *Patients*
  Reach out to patients; they talk, too, and in many cases may be with a new employer soon. Such a patient focus makes even more sense in an employee-choice state.
- *Your own organization*
  Considerable leverage is often available close to home. For example, many staff members may have a spouse who works at a target company, or a friend or neighbor at one of your high-profile prospect companies. Potential entrees may be, as they say, right under your nose.

Leveraging existing relationships should filter though every aspect of your sales and marketing plan. If your clinic limits itself solely to bilateral communication with prospects, you are shortchanging your ability to generate additional business. ■

Next month in Occupational Medicine:
Making Employer Advisory Councils Work for You

TAKE-HOME POINTS

- Selling additional services to existing clients—as opposed to only adding new clients—is a good way to grow the business.
- Using satisfied customers as references makes good marketing sense.
- Referrals for potential new clients can come from referring physicians and payors, patients, and your own employees.

DEVELOPING DATA

UCAOA'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: Just what constitutes an "average" business day for an urgent care clinic?

CLINIC HOURS

	Open	Respondents	Close	Respondents
Monday - Friday	7 a.m.	(10 %)	7 p.m.	(10%)
	8 a.m.	(58%)	8 p.m.	(42%)
	9 a.m.	(20%)	9 p.m.	(13%)
			10 p.m.	(11%)
Saturday	8 a.m.	(34%)	5 p.m.	(18%)
	9 a.m.	(36%)	6 p.m.	(12%)
	10 a.m.	(13%)	8 p.m.	(22%)
			9 p.m.	(10%)
Sunday	8 a.m.	(24%)	4 p.m.	(12%)
	9 a.m.	(28%)	5 p.m.	(21%)
	10 a.m.	(18%)	6 p.m.	(17%)
	11 a.m.	(12%)	8 p.m.	(13%)
			9 p.m.	(11%)

Source: *Benchmarking Your Urgent Care*, © 2006, **Urgent Care Association of America**.

One of the perceived benefits of urgent care, from a patient's perspective, is convenience; clinics tend to be open when the primary care provider's doors are closed, and care more quickly available than in the ED of the local hospital. But what does that mean, in terms of hours of operation?

More than half of respondents report that their clinic is open from 8 a.m. or earlier to 8 p.m. or later on weekdays.

Typically, hours change slightly on weekends. Only 34% of respondents' clinics open at 8 a.m. on Saturday, while 36% open their doors at 9; 13% don't see their first patient until 10 a.m.

Business hours are most disparate on Sundays, when 12% of respondents open at 11 a.m. and closing times are staggered from 4 p.m. (for 12% of survey participants), to 9 p.m. (11%). Most close at 5 or 6 p.m. on Sundays, though.

Next month in ***Developing Data****:*

Urgent care providers are often distinguished from their counterparts who practice in other settings by virtue of the fact that they are entrepreneurs who started their own business. We'll look at the corporate structure/organization of urgent care as revealed by the UCAOA survey.

LEVAQUIN® (levofloxacin) TABLETS
LEVAQUIN® (levofloxacin) ORAL SOLUTION
LEVAQUIN® (levofloxacin) INJECTION
LEVAQUIN® (levofloxacin in 5% dextrose) INJECTION

Brief Summary

The following is a brief summary only. Before prescribing, see complete Prescribing Information in LEVAQUIN Tablets/Oral Solution/Injection labeling.

To reduce the development of drug-resistant bacteria and maintain the effectiveness of LEVAQUIN® (levofloxacin) and other antibacterial drugs, LEVAQUIN should be used only to treat or prevent infections that are proven or strongly suspected to be caused by bacteria.

CONTRAINDICATIONS: Levofloxacin is contraindicated in persons with a history of hypersensitivity to levofloxacin, quinolone antimicrobial agents, or any other components of this product.

WARNINGS: THE SAFETY AND EFFICACY OF LEVOFLOXACIN IN PEDIATRIC PATIENTS, ADOLESCENTS (UNDER THE AGE OF 18 YEARS), PREGNANT WOMEN, AND NURSING WOMEN HAVE NOT BEEN ESTABLISHED. (See **PRECAUTIONS: Pediatric Use, Pregnancy,** and **Nursing Mothers** subsections.)

In immature rats and dogs, the oral and intravenous administration of levofloxacin resulted in increased osteochondrosis. Histopathological examination of the weight-bearing joints of immature dogs dosed with levofloxacin revealed persistent lesions of the cartilage. Other fluoroquinolones also produce similar erosions in the weight bearing joints and other signs of arthropathy in immature animals of various species. The relevance of these findings to the clinical use of levofloxacin is unknown. (See **ANIMAL PHARMACOLOGY** in full Prescribing Information.)

Convulsions and toxic psychoses have been reported in patients receiving quinolones, including levofloxacin. Quinolones may also cause increased intracranial pressure and central nervous system stimulation which may lead to tremors, restlessness, anxiety, lightheadedness, confusion, hallucinations, paranoia, depression, nightmares, insomnia, and, rarely, suicidal thoughts or acts. These reactions may occur following the first dose. If these reactions occur in patients receiving levofloxacin, the drug should be discontinued and appropriate measures instituted. As with other quinolones, levofloxacin should be used with caution in patients with a known or suspected CNS disorder that may predispose to seizures or lower the seizure threshold (e.g., severe cerebral arteriosclerosis, epilepsy) or in the presence of other risk factors that may predispose to seizures or lower the seizure threshold (e.g., certain drug therapy, renal dysfunction.) (See **PRECAUTIONS: General, Information for Patients, Drug Interactions** and **ADVERSE REACTIONS.**)

Serious and occasionally fatal hypersensitivity and/or anaphylactic reactions have been reported in patients receiving therapy with quinolones, including levofloxacin. These reactions often occur following the first dose. Some reactions have been accompanied by cardiovascular collapse, hypotension/shock, seizure, loss of consciousness, tingling, angioedema (including tongue, laryngeal, throat, or facial edema/swelling), airway obstruction (including bronchospasm, shortness of breath, and acute respiratory distress), dyspnea, urticaria, itching, and other serious skin reactions. Levofloxacin should be discontinued immediately at the first appearance of a skin rash or any other sign of hypersensitivity. Serious acute hypersensitivity reactions may require treatment with epinephrine and other resuscitative measures, including oxygen, intravenous fluids, antihistamines, corticosteroids, pressor amines, and airway management, as clinically indicated. (See **PRECAUTIONS** and **ADVERSE REACTIONS.**)

Serious and sometimes fatal events, some due to hypersensitivity, and some due to uncertain etiology, have been reported rarely in patients receiving therapy with quinolones, including levofloxacin. These events may be severe and generally occur following the administration of multiple doses. Clinical manifestations may include one or more of the following: fever, rash or severe dermatologic reactions (e.g., toxic epidermal necrolysis, Stevens-Johnson Syndrome); vasculitis; arthralgia; myalgia; serum sickness; allergic pneumonitis; interstitial nephritis; acute renal insufficiency or failure; hepatitis; jaundice; acute hepatic necrosis or failure; anemia, including hemolytic and aplastic; thrombocytopenia, including thrombotic thrombocytopenic purpura; leukopenia; agranulocytosis; pancytopenia; and/or other hematologic abnormalities. The drug should be discontinued immediately at the first appearance of a skin rash or any other sign of hypersensitivity and supportive measures instituted. (See **PRECAUTIONS: Information for Patients** and **ADVERSE REACTIONS.**)

Peripheral Neuropathy: Rare cases of sensory or sensorimotor axonal polyneuropathy affecting small and/or large axons resulting in paresthesias, hypoesthesias, dysesthesias and weakness have been reported in patients receiving quinolones, including levofloxacin. Levofloxacin should be discontinued if the patient experiences symptoms of neuropathy including pain, burning, tingling, numbness, and/or weakness or other alterations of sensation including light touch, pain, temperature, position sense, and vibratory sensation in order to prevent the development of an irreversible condition.

Pseudomembranous colitis has been reported with nearly all antibacterial agents, including levofloxacin, and may range in severity from mild to life-threatening. Therefore, it is important to consider this diagnosis in patients who present with diarrhea subsequent to the administration of any antibacterial agent.

Treatment with antibacterial agents alters the normal flora of the colon and may permit overgrowth of clostridia. Studies indicate that a toxin produced by *Clostridium difficile* is one primary cause of "antibiotic-associated colitis."

After the diagnosis of pseudomembranous colitis has been established, therapeutic measures should be initiated. Mild cases of pseudomembranous colitis usually respond to drug discontinuation alone. In moderate to severe cases, consideration should be given to management with fluids and electrolytes, protein supplementation, and treatment with an antibacterial drug clinically effective against *C. difficile* colitis. (See **ADVERSE REACTIONS.**)

Tendon Effects: Ruptures of the shoulder, hand, Achilles tendon, or other tendons that required surgical repair or resulted in prolonged disability have been reported in patients receiving quinolones, including levofloxacin. Post-marketing surveillance reports indicate that this risk may be increased in patients receiving concomitant corticosteroids, especially the elderly. Levofloxacin should be discontinued if the patient experiences pain, inflammation, or rupture of a tendon. Patients should rest and refrain from exercise until the diagnosis of tendonitis or tendon rupture has been confidently excluded. Tendon rupture can occur during or after therapy with quinolones, including levofloxacin.

PRECAUTIONS: General Prescribing LEVAQUIN in the absence of a proven or strongly suspected bacterial infection or a prophylactic indication is unlikely to provide benefit to the patient and increases the risk of the development of drug-resistant bacteria.

Because a rapid or bolus intravenous injection may result in hypotension, LEVOFLOXACIN INJECTION SHOULD ONLY BE ADMINISTERED BY SLOW INTRAVENOUS INFUSION OVER A PERIOD OF 60 OR 90 MINUTES DEPENDING ON THE DOSAGE. (See **DOSAGE AND ADMINISTRATION** in full Prescribing Information.)

Although levofloxacin is more soluble than other quinolones, adequate hydration of patients receiving levofloxacin should be maintained to prevent the formation of a highly concentrated urine.

Administer levofloxacin with caution in the presence of renal insufficiency. Careful clinical observation and appropriate laboratory studies should be performed prior to and during therapy since elimination of levofloxacin may be reduced. In patients with impaired renal function (creatinine clearance <50 mL/min), adjustment of the dosage regimen is necessary to avoid the accumulation of levofloxacin due to decreased clearance. (See **CLINICAL PHARMACOLOGY** and **DOSAGE AND ADMINISTRATION** in full Prescribing Information.)

Moderate to severe phototoxicity reactions have been observed in patients exposed to direct sunlight while receiving drugs in this class. Excessive exposure to sunlight should be avoided. However, in clinical trials with levofloxacin, phototoxicity has been observed in less than 0.1% of patients. Therapy should be discontinued if phototoxicity (e.g., a skin eruption) occurs.

As with other quinolones, levofloxacin should be used with caution in any patient with a known or suspected CNS disorder that may predispose to seizures or lower the seizure threshold (e.g., severe cerebral arteriosclerosis, epilepsy) or in the presence of other risk factors that may predispose to seizures or lower the seizure threshold (e.g., certain drug therapy, renal dysfunction). (See **WARNINGS** and **Drug Interactions.**)

As with other quinolones, disturbances of blood glucose, including symptomatic hyper- and hypoglycemia, have been reported, usually in diabetic patients receiving concomitant treatment with an oral hypoglycemic agent (e.g., glyburide/glibenclamide) or with insulin. In these patients, careful monitoring of blood glucose is recommended. If a hypoglycemic reaction occurs in a patient being treated with levofloxacin, levofloxacin should be discontinued immediately and appropriate therapy should be initiated immediately. (See **Drug Interactions** and **ADVERSE REACTIONS.**)

Torsades de pointes: Some quinolones, including levofloxacin, have been associated with prolongation of the QT interval on the electrocardiogram and infrequent cases of arrhythmia. Rare cases of torsades de pointes have been spontaneously reported during post-marketing surveillance in patients receiving quinolones, including levofloxacin. Levofloxacin should be avoided in patients with known prolongation of the QT interval, patients with uncorrected hypokalemia, and patients receiving class IA (quinidine, procainamide), or class III (amiodarone, sotalol) antiarrhythmic agents.

As with any potent antimicrobial drug, periodic assessment of organ system functions, including renal, hepatic, and hematopoietic, is advisable during therapy. (See **WARNINGS** and **ADVERSE REACTIONS.**)

Information for Patients

Patients should be advised:

- Patients should be counseled that antibacterial drugs including LEVAQUIN® (levofloxacin) should only be used to treat bacterial infections. They do not treat viral infections (e.g., the common cold). When LEVAQUIN is prescribed to treat a bacterial infection, patients should be told that although it is common to feel better early in the course of therapy, the medication should be taken exactly as directed. Skipping doses or not completing the full course of therapy may (1) decrease the effectiveness of the immediate treatment and (2) increase the likelihood that bacteria will develop resistance and will not be treatable by LEVAQUIN or other antibacterial drugs in the future;
- that peripheral neuropathies have been associated with levofloxacin use. If symptoms of peripheral neuropathy including pain, burning, tingling, numbness, and/or weakness develop, they should discontinue treatment and contact their physicians;
- to drink fluids liberally;
- that antacids containing magnesium, or aluminum, as well as sucralfate, metal cations such as iron, and multivitamin preparations with zinc or Videx® (didanosine) should be taken at least two hours before or two hours after oral levofloxacin administration. (See **Drug Interactions**);
- that levofloxacin oral tablets can be taken without regard to meals;
- that levofloxacin oral solution should be taken 1 hour before or 2 hours after eating;
- that levofloxacin may cause neurologic adverse effects (e.g., dizziness, lightheadedness) and that patients should know how they react to levofloxacin before they operate an automobile or machinery or engage in other activities requiring mental alertness and coordination. (See **WARNINGS** and **ADVERSE REACTIONS**);
- to discontinue treatment and inform their physician if they experience pain, inflammation, or rupture of a tendon, and to rest and refrain from exercise until the diagnosis of tendinitis or tendon rupture has been confidently excluded;
- that levofloxacin may be associated with hypersensitivity reactions, even following the first dose, and to discontinue the drug at the first sign of a skin rash, hives or other skin reactions, a rapid heartbeat, difficulty in swallowing or breathing, any swelling suggesting angioedema (e.g., swelling of the lips, tongue, face, tightness of the throat, hoarseness), or other symptoms of an allergic reaction. (See **WARNINGS** and **ADVERSE REACTIONS**);
- to avoid excessive sunlight or artificial ultraviolet light while receiving levofloxacin and to discontinue therapy if phototoxicity (i.e., skin eruption) occurs;
- that if they are diabetic and are being treated with insulin or an oral hypoglycemic agent and a hypoglycemic reaction occurs, they should discontinue levofloxacin and consult a physician. (See **PRECAUTIONS: General** and **Drug Interactions.**);
- that concurrent administration of warfarin and levofloxacin has been associated with increases of the International Normalized Ratio (INR) or prothrombin time and clinical episodes of bleeding. Patients should notify their physician if they are taking warfarin.
- that convulsions have been reported in patients taking quinolones, including levofloxacin, and to notify their physician before taking this drug if there is a history of this condition.

Drug Interactions: Antacids, Sucralfate, Metal Cations, Multivitamins

LEVAQUIN Tablets: While the chelation by divalent cations is less marked than with other quinolones, concurrent administration of LEVAQUIN Tablets with antacids containing magnesium, or aluminum, as well as sucralfate, metal cations such as iron, and multivitamin preparations with zinc may interfere with the gastrointestinal absorption of levofloxacin, resulting in systemic levels considerably lower than desired. Tablets with antacids containing magnesium, aluminum, as well as sucralfate, metal cations such as iron, and multivitamins preparations with zinc or Videx® (didanosine) may substantially interfere with the gastrointestinal absorption of levofloxacin, resulting in systemic levels considerably lower than desired. These agents should be taken at least two hours before or two hours after levofloxacin administration.

LEVAQUIN Injection: There are no data concerning an interaction of **intravenous** quinolones with **oral** antacids, sucralfate, multivitamins, Videx® (didanosine), or metal cations. However, no quinolone should be co-administered with any solution containing multivalent cations, e.g., magnesium, through the same intravenous line. (See **DOSAGE AND ADMINISTRATION** in full Prescribing Information.)

Theophylline: No significant effect of levofloxacin on the plasma concentrations, AUC, and other disposition parameters for theophylline was detected in a clinical study involving 14 healthy volunteers. Similarly, no apparent effect of theophylline on levofloxacin absorption and disposition was observed. However, concomitant administration of other quinolones with theophylline has resulted in prolonged elimination half-life, elevated serum theophylline levels, and a subsequent increase in the risk of theophylline-related adverse reactions in the patient population. Therefore, theophylline levels should be closely monitored and appropriate dosage adjustments made when levofloxacin is co-administered. Adverse reactions, including seizures, may occur with or without an elevation in serum theophylline levels. (See **WARNINGS** and **PRECAUTIONS: General.**)

Warfarin: No significant effect of levofloxacin on the peak plasma concentrations, AUC, and other disposition parameters for R- and S-warfarin was detected in a clinical study involving healthy volunteers. Similarly, no apparent effect of warfarin on levofloxacin absorption and disposition was observed. There have been reports during the post-marketing experience in patients that levofloxacin enhances the effects of warfarin. Elevations of the prothrombin time in the setting of concurrent warfarin and levofloxacin use have been associated with episodes of bleeding. Prothrombin time, International Normalized Ratio (INR), or other suitable anticoagulation tests should be closely monitored if levofloxacin is administered concomitantly with warfarin. Patients should also be monitored for evidence of bleeding.

Cyclosporine: No significant effect of levofloxacin on the peak plasma concentrations, AUC, and other disposition parameters for cyclosporine was detected in a clinical study involving healthy volunteers. However, elevated serum levels of cyclosporine have been reported in the patient population when co-administered with some other quinolones. Levofloxacin C_{max} and k_e were slightly lower while T_{max} and $t_{1/2}$ were slightly longer in the presence of cyclosporine than those observed in other studies without concomitant medication. The differences, however, are not considered to be clinically significant. Therefore, no dosage adjustment is required for levofloxacin or cyclosporine when administered concomitantly.

Digoxin: No significant effect of levofloxacin on the peak plasma concentrations, AUC, and other disposition parameters for digoxin was detected in a clinical study involving healthy volunteers. Levofloxacin absorption and disposition kinetics were similar in the presence or absence of digoxin. Therefore, no dosage adjustment for levofloxacin or digoxin is required when administered concomitantly.

Probenecid and Cimetidine: No significant effect of probenecid or cimetidine on the rate and extent of levofloxacin absorption was observed in a clinical study involving healthy volunteers. The AUC and $t_{1/2}$ of levofloxacin were 27-38% and 30% higher, respectively, while CL/F and CL_R were 21-35% lower during concomitant treatment with probenecid or cimetidine compared to levofloxacin alone. Although these differences were statistically significant, the changes were not high enough to warrant dosage adjustment for levofloxacin when probenecid or cimetidine is co-administered.

Non-steroidal anti-inflammatory drugs: The concomitant administration of a non-steroidal anti-inflammatory drug with a quinolone, including levofloxacin, may increase the risk of CNS stimulation and convulsive seizures. (See **WARNINGS** and **PRECAUTIONS: General.**)

Antidiabetic agents: Disturbances of blood glucose, including hyperglycemia and hypoglycemia, have been reported in patients treated concomitantly with quinolones and an antidiabetic agent. Therefore, careful monitoring of blood glucose is recommended when these agents are co-administered.

Interaction with Laboratory or Diagnostic Testing: Some quinolones, including levofloxacin, may produce false-positive urine screening results for opiates using commercially available immunoassay kits. Confirmation of positive opiate screens by more specific methods may be necessary.

Carcinogenesis, Mutagenesis, Impairment of Fertility: In a lifetime bioassay in rats, levofloxacin exhibited no carcinogenic potential following daily dietary administration for 2 years; the highest dose (100 mg/kg/day) was 1.4 times the highest recommended human dose (750 mg) based upon relative body surface area. Levofloxacin did not shorten the time to tumor development of UV-induced skin tumors in hairless albino (Skh-1) mice at any levofloxacin dose level and was therefore not photo-carcinogenic under conditions of this study. Dermal levofloxacin concentrations in the hairless mice ranged from 25 to 42 µg/g at the highest levofloxacin dose level (300 mg/kg/day) used in the photo-carcinogenicity study. By comparison, dermal levofloxacin concentrations in human subjects receiving 750 mg of levofloxacin averaged approximately 11.8 µg/g at C_{max}.

Levofloxacin was not mutagenic in the following assays: Ames bacterial mutation assay (*S. typhimurium* and *E. coli*), CHO/HGPRT forward mutation assay, mouse micronucleus test, mouse dominant lethal test, rat unscheduled DNA synthesis assay, and the mouse sister chromatid exchange assay. It was positive in the in vitro chromosomal aberration (CHL cell line) and sister chromatid exchange (CHL/IU cell line) assays.

Levofloxacin caused no impairment of fertility or reproductive performance in rats at oral doses as high as 360 mg/kg/day, corresponding to 4.2 times the highest recommended human dose based upon relative body surface area and intravenous doses as high as 100 mg/kg/day, corresponding to 1.2 times the highest recommended human dose based upon relative body surface area.

Pregnancy: Teratogenic Effects. Pregnancy Category C.: Levofloxacin was not teratogenic in rats at oral doses as high as 810 mg/kg/day which corresponds to 9.4 times the highest recommended human dose based upon relative body surface area, or at intravenous doses as high as 160 mg/kg/day corresponding to 1.9 times the highest recommended human dose based upon relative body surface area. The oral dose of 810 mg/kg/day to rats caused decreased fetal body weight and increased fetal mortality. No teratogenicity was observed when rabbits were dosed orally as high as 50 mg/kg/day which corresponds to 1.1 times the highest recommended human dose based upon relative body surface area, or when dosed intravenously as high as 25 mg/kg/day, corresponding to 0.5 times the highest recommended human dose based upon relative body surface area.

There are, however, no adequate and well-controlled studies in pregnant women. Levofloxacin should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus. (See **WARNINGS.**)

Nursing Mothers: Levofloxacin has not been measured in human milk. Based upon data from ofloxacin, it can be presumed that levofloxacin will be excreted in human milk. Because of the potential for serious adverse reactions from levofloxacin in nursing infants, a decision should be made whether to discontinue nursing or to discontinue the drug, taking into account the importance of the drug to the mother.

Pediatric Use: Safety and effectiveness in pediatric patients and adolescents below the age of 18 years have not been established. Quinolones, including levofloxacin, cause arthropathy and osteochondrosis in juvenile animals of several species. (See **WARNINGS.**)

Geriatric Use: In phase 3 clinical trials, 1,190 levofloxacin-treated patients (25%) were ≥65 years of age. Of these, 675 patients (14%) were between the ages of 65 and 74 and 515 patients (11%) were 75 years or older. No overall differences in safety or effectiveness were observed between these subjects and younger subjects, and other reported clinical experience has not identified differences in responses between the elderly and younger patients, but greater sensitivity of some older individuals cannot be ruled out.

Elderly patients may be more susceptible to drug-associated effects on the QT interval. Therefore, precaution should be taken when using levofloxacin with concomitant drugs that can result in prolongation of the QT interval (e.g. class IA or class III antiarrhythmics) or in patients with risk factors for Torsades de pointes (e.g. known QT prolongation, uncorrected hypokalemia). See **PRECAUTIONS: GENERAL:** Torsades de Pointes.

The pharmacokinetic properties of levofloxacin in younger adults and elderly adults do not differ significantly when creatinine clearance is taken into consideration. However since the drug is known to be substantially excreted by the kidney, the risk of toxic reactions to this drug may be greater in patients with impaired renal function. Because elderly patients are more likely to have decreased renal function, care should be taken in dose selection, and it may be useful to monitor renal function.

ADVERSE REACTIONS: The incidence of drug-related adverse reactions in patients during Phase 3 clinical trials conducted in North America was 6.7%. Among patients receiving levofloxacin therapy, 4.1% discontinued levofloxacin therapy due to adverse experiences. In all Phase III trials, the overall incidence, type and distribution of adverse events was similar in patients receiving levofloxacin doses of 750 mg once daily, 250 mg once daily, and 500 mg once or twice daily.

In clinical trials, the following events were considered likely to be drug-related in patients receiving levofloxacin: nausea 1.5%, diarrhea 1.2%, vaginitis 0.5%, insomnia 0.4%, abdominal pain 0.4%, flatulence 0.2%, pruritus 0.2%, dizziness 0.3%, rash 0.3%, dyspepsia 0.3%, genital moniliasis 0.1%, moniliasis 0.2%, taste perversion 0.2%, vomiting 0.3%, injection site pain 0.2%, injection site reaction 0.1%, injection site inflammation 0.1%, constipation 0.1%, fungal infection 0.1%, genital pruritis 0.1%, headache 0.2%, nervousness 0.1%, rash erythematous 0.1%, urticaria 0.1%, anorexia 0.1%, somnolence 0.1%, agitation 0.1%, rash maculo-papular (<0.1%), dry mouth 0.2%, tremor 0.1%, condition aggravated 0.1%, allergic reaction 0.1%.

In clinical trials, the following events occurred in >3% of patients, regardless of drug relationship: nausea 6.8%, headache 5.8%, diarrhea 5.4%, insomnia 4.6%, constipation 3.1%.

In clinical trials, the following events occurred in 1 to 3% of patients, regardless of drug relationship: abdominal pain 2.5%, dizziness 2.4%, vomiting 2.4%, dyspepsia 2.3%, vaginitis 1.3%, rash 1.4%, chest pain 1.2%, pruritus 1.2%, sinusitis 1.1%, dyspnea 1.3%, fatigue 1.2%, flatulence 1.2%, pain 1.3%, back pain 1.2%, rhinitis 1.2%, pharyngitis 1.1%.

In clinical trials, the following events, of potential medical importance, occurred at a rate of 0.1% to 0.9%, regardless of drug relationship:

Body as a Whole – General Disorders: Ascites, allergic reaction, asthenia, edema, fever, headache, hot flashes, influenza-like symptoms, leg pain, malaise, rigors, substernal chest pain, syncope, multiple organ failure, changed temperature sensation, withdrawal syndrome; Cardiovascular Disorders, General: Cardiac failure, hypertension, hypertension aggravated, hypotension, postural hypotension; Central and Peripheral Nervous System Disorders: Convulsions (seizures), hyperesthesia, hyperkinesia, hypertonia, hypoesthesia, involuntary muscle contractions, migraine, paresthesia, paralysis, speech disorder, stupor, tremor, vertigo, encephalopathy, abnormal gait, leg cramps, intracranial hypertension, ataxia; Gastro-Intestinal System Disorders: Dry mouth, dysphagia, esophagitis, gastritis, gastroesophageal reflux, G.I. hemorrhage, glossitis, intestinal obstruction, pancreatitis, tongue edema, melena, stomatitis; Hearing and Vestibular Disorders: Earache, ear disorder NOS, tinnitus; Heart Rate and Rhythm Disorders: Arrhythmia, arrhythmia ventricular, atrial fibrillation, bradycardia, cardiac arrest, ventricular fibrillation, heart block, palpitation, supraventricular tachycardia, ventricular tachycardia, tachycardia; Liver and Biliary System Disorders: Abnormal hepatic function, cholecystitis, cholelithiasis, hepatic enzymes increased, hepatic failure, jaundice; Metabolic and Nutritional Disorders: Hypomagnesemia, thirst, dehydration, electrolyte abnormality, fluid overload, gout, hyperglycemia, hyperkalemia, hypernatremia, hypoglycemia, hypokalemia, hyponatremia, hypophosphatemia, nonprotein nitrogen increase, weight decrease; Musculo-Skeletal System Disorders: Arthralgia, arthritis, arthrosis, myalgia, osteomyelitis, skeletal pain, synovitis, tendonitis, tendon disorder; Myo, Endo, Pericardial and Valve Disorders: Angina pectoris, myocardial infarction; Neoplasms: Carcinoma, thrombocythemia; Other Special Senses Disorders: Parosmia, taste perversion; Platelet, Bleeding and Clotting Disorders: Hematoma, epistaxis, prothrombin decreased, pulmonary embolism, purpura, thrombocytopenia; Psychiatric Disorders: Abnormal dreaming, agitation, anorexia, anxiety, confusion, depression, hallucination, impotence, nervousness, paroniria, sleep disorder, somnolence; Red Blood Cell Disorders: Anemia; Reproductive Disorders: Dysmenorrhea, leucorrhea; Resistance Mechanism Disorders: Abscess, bacterial infection, fungal infection, herpes simplex, moniliasis, otitis media, sepsis, infection; Respiratory System Disorders: Airways obstruction, aspiration, asthma, bronchitis, bronchospasm, chronic obstructive airway disease, coughing, hemoptysis, epistaxis, hypoxia, laryngitis, pleural effusion, pleurisy, pneumonitis, pneumonia, pneumothorax, pulmonary edema, respiratory depression, respiratory disorder, respiratory insufficiency, upper respiratory tract infection; Skin and Appendages Disorders: Alopecia, bullous eruption, dry skin, eczema, genital pruritus, increased sweating, rash, skin disorder, skin exfoliation, skin ulceration, urticaria; Urinary System Disorders: Abnormal renal function, acute renal failure, hematuria, oliguria, urinary incontinence, urinary retention, urinary tract infection; Vascular (Extracardiac) Disorders: Flushing, cerebrovascular disorder, gangrene, phlebitis, purpura, thrombophlebitis (deep); Vision Disorders: Abnormal vision, eye pain, conjunctivitis; White Cell and RES Disorders: Agranulocytosis, granulocytopenia, leukocytosis, lymphadenopathy, WBC abnormal NOS.

In clinical trials using multiple-dose therapy, ophthalmologic abnormalities, including cataracts and multiple punctate lenticular opacities, have been noted in patients undergoing treatment with other quinolones. The relationship of the drugs to these events is not presently established.

Crystalluria and cylindruria have been reported with other quinolones.

The following markedly abnormal laboratory values appeared in >2% of patients receiving levofloxacin. It is not known whether this abnormality was caused by the drug or the underlying condition being treated.

Hematology: decreased lymphocytes (2.2%)

Post-Marketing Adverse Reactions: Additional adverse events reported from worldwide post-marketing experience with levofloxacin include: allergic pneumonitis, anaphylactic shock, anaphylactoid reaction, dysphonia, abnormal EEG, encephalopathy, eosinophilia, erythema multiforme, hemolytic anemia, multi-system organ failure, increased International Normalized Ratio (INR)/prothrombin time, peripheral neuropathy, rhabdomyolysis, Stevens-Johnson Syndrome, tendon rupture, torsades de pointes, vasodilation.

ORTHO-McNEIL

OMP DIVISION
ORTHO-McNEIL PHARMACEUTICAL, INC.
Raritan, New Jersey, USA 08869

U.S. Patent No. 5,053,407.

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Indications:

* LEVAQUIN is indicated for adults with acute bacterial sinusitis due to *S. pneumoniae, H. influenzae,* or *M. catarrhalis*.

† 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.

‖ Videx is a registered trademark of Bristol-Myers Squibb Company.

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For more information, visit us at www.levaquin.com

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