LETTERS TO THE EDITOR

Regarding Our January and May Issues

CA-MRSA

To the Editor:

I just finished your excellent article on treating CA-MRSA (CA-MRSA Abscess Care and Treatment Guidelines in Urgent Care Practice, Michael Dickey, MD, *JUCM*, January 2008). I agree with most everything I saw there. But I challenge one assertion made by the author.

Dr. Dickey seems to imply that *all* abscesses require packing. I have performed incision and drainage on well over 100 laboratory-confirmed MRSA abscesses, and rarely place any packing. I realize that this is not a scientific study, but I checked on the last 50 patients I did not pack, and every single one of them healed without any trouble. I will occasionally pack a "large" abscess (very subjective, I know—usually over 4 cm).

Urgent care medicine is a rapidly growing and changing specialty. I think we need to be careful when we use absolute terms like "always" and "must," especially since there are many more lawyers in this country than urgent care docs!

None of this is to imply that I do not use antibiotics when treating CA-MRSA; typically, I use dual antibiotic coverage for all but the smallest of abscesses.

John S. White II, MD
Convenient Care/The Jackson Clinic
Jackson, TN

Dr. Dickey responds: Dr. White makes an excellent point, and I would agree that packing these wounds should not be considered an absolute. Wound packing can be a useful tool, but only if used briefly. Certainly many small superficial abscesses do not require packing.

Also, good wound care can maintain a drain passage for inflammatory exudate and allows even somewhat larger wounds to remain drained satisfactorily without packing or drain.

My intended point was the importance of maintaining wound drainage, but my wording should have been more careful. Thank you, Dr. White, for the clarification.

Bouncebacks

To the Editor:

I enjoyed reading the article The Case of a 71-Year-Old Man with Back Pain (Bouncebacks, Michael B. Weinstock, MD and Ryan Longstreth, MD, FACEP, *JUCM*, May 2008). However, even the authors omitted, in their critique, the most important diagnostic clinical test: blood pressure in the lower limb.

Normally, the blood pressure in the lower limb is higher than the upper limb. In AAA, it is reversed.

Admittedly, it sometimes takes awhile (no longer than five minutes) to get a thigh cuff reading, but they could have had a presumptive diagnoses following the Hs + PE.

T. Paul Evans, MD
Clyde I. Deffenbaugh Occupational Health Center
Circleville, OH

Drs. Weinstock and Longstreth respond: If an abdominal aortic aneurysm is suspected, the test needs to be definitive, as misdiagnosis and rupture result in almost assured death.

In 2004, Teece, et al, did a meta-analysis of 1,586 patients and found a peripheral pulse deficit to be present only 31% of the time with thoracic dissection (Best evidence topic report. Peripheral pulses to exclude thoracic aortic dissection. *Emerg Med J*. 2004;21(5):589.)

In 2000, Fink, et al, looked at physical examination in patients with AAA and found the sensitivity and specificity of abdominal palpation for AAA were 68% and 75%, respectively. (The accuracy of physical examination to detect abdominal aortic aneurysm. *Arch Intern Med*. 2000;160(6):833-836).

Though we were unable to find a good study showing the clinical utility of lower extremity blood pressures, we do know that a bedside ultrasound is almost 100% sensitive, as is CT. Though ultrasound is not commonly performed in the urgent care setting, we feel strongly that a patient with a suspected AAA needs a definitive test.

Calcaneal Fractures

To the Editor:

Thanks for the interesting Clinical Images of a patient with bilateral calcaneal fractures from a fall, presumably in which the patient landed on both feet (Insights in Images: Clinical Challenge, presented by Nahum Kovalski, BSc, MDCM, *JUCM*, May 2008). It may be worth noting that these patients also require careful

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"Calcaneal fractures have a high (10% to 15%) incidence of associated lumbar fractures and/or proximal lower extremity injuries."

examination of the spine, as this mechanism of injury not infrequently results in concomitant vertebral compression fractures.

Mark Epstein, MD, MBA
Presbyterian Health Services Urgent Care Clinics
Albuquerque, NM

To the Editor:
The author failed to mention that calcaneal fractures have a high (10% to 15%) incidence of associated lumbar fractures (reference: eMedicine.com article "Calcaneal Fractures" by Scott Nicklebur, MD).

Margaret Szafranski, RN, MS, APN
Christie Clinic
Champaign, IL

To the Editor:
The case of bilateral calcaneal fractures featured very nice images, but I thought the Resolution should have included the fact that 10% to 15% of these injuries are associated with spinal compression fractures and/or proximal lower extremity injuries. The author of this case mentioned only to examine the contralateral extremity for associated injury. As you know, we need to be mindful to examine the patient in entirety to exclude these injuries.

Julie Lavinder, MD
Family Care Now
Louisville, OH

Dr. Kovalski responds: The comments made are excellent and to the point. We need to make sure always to expand on the discussion of the x-rays, rather than just focus the discussion on the immediate issue. Lesson learned. Thank you.

[Editor's note: We welcome letters regarding how you would handle cases described in Insights in Images. Our intent in presenting those cases in the journal is to relay how specific, real-life cases were managed using the information and images available at the time of presentation.]

Care to comment?
If you have a comment or question regarding an article you've read in *JUCM*, please let us know with an e-mail to *editor@jucm.com*. We'll ask the author to respond, and print the exchange here in an upcoming issue.