LETTERS TO THE EDITOR

Regarding Our January Issue

To the Editor:
I enjoyed the article about CA-MRSA (CA-MRSA Abscess Care and Treatment Guidelines in Urgent Care Practice, Michael Dickey, MD, *JUCM*, January 2008).

Community-acquired MRSA is indeed becoming more and more common. In fact, it has been referred to as "the spider bite of the twenty-first century."

Any abscess seen in the outpatient setting should be considered MRSA until proven otherwise and treated for both MRSA and MSSA and *Strep*. All abscesses should have an I & D, and a culture should be sent so the susceptibilities in your area can be determined.

Concerning cellulitis, MRSA should not be automatically assumed. But, if you are treating for normal skin flora and there is no improvement in a few days, or if it worsens, treatment for MRSA should be added to the current antibiotic regimen.

One other note about other organisms that cause skin and soft tissue infections: don't forget *Mycobacterium marinum*. Think of it if your patient recently was in the Caribbean or recently had a pedicure and presents with a toe infection.

Joseph A. LiMarzi, MD
Assistant Director, Milford Urgent Care Center, Milford, PA
Assistant Director, Emergency Department, Newton Memorial Hospital, Newton, NJ

***Dr. Dickey responds*:** I agree with Dr. LiMarzi's thoughts on atypical infections. Mycobacterial and fungal infections should be suspected when an SSTI is not responsive to therapy directed at MRSA and *Streptococcus*. AFB and fungal cultures and stains, as well as biopsy of infected site, can be helpful to help determine the etiology of non-responsive infections.

These infections often require a little CSI (crime scene investigator) work; often, infectious disease consultants can be very helpful in sorting these infections out. As they are particularly infrequent, most clinicians in the trenches are going to see very few of them.

To the Editor:
The picture of an ankle x-ray on page 27 (Insights in Images: Clinical Challenge, presented by Nahum Kovalski, BSc, MDCM, *JUCM*, January 2008) points out the widened joint space on the medial side of the ankle.

Having been an orthopedic resident through the PGY3 level prior to my emergency medicine residency, I would point out that concern over that widened space should have led the clinician to investigate whether there was a concomitant proximal fibula fracture.

The whole point of that x-ray is that the energy which was absorbed and caused disruption of the deltoid ligament often travels up through the syndesmosis between the tibia and fibula and exits through the proximal fibula.

I agree that splinting is necessary, but I do think the answer was excessively basic for physicians in urgent care. The above explanation is the reason why that x-ray is a unique teaching point, not that a splint is necessary.

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***Dr. Kovalski responds*:** Our orthopedist notes that in such cases, a physical exam of the proximal fibular region to rule out sensitivity (consistent with a fracture) is the appropriate next step. If there is tenderness, a film to that area is necessary. If there is no proximal tenderness, then a film would not be necessary.

To the Editor:
I couldn't agree more on how important marketing is in achieving successful results in occupational medicine (The Physician's Role in Occupational Health Sales and Marketing, Frank Leone, MBA, MPH, *JUCM*, January 2008).

In our occupational division, our marketers know firsthand all the services our providers offer.

In our facility, we have implemented a quality-assurance command center which monitors all services to avoid over-utilization. The program assures that the injured worker and the employer receive efficient and professional attention.

Despite personalized and creative marketing tools, competition will always be a challenge. Open employer–physician communication, dedication to comprehensive case management, and healthcare cost containment will definitely differentiate between you and your competitor.

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