



# On Retail Clinics, Bell Palsy, and Abscesses: to Pack or Not to Pack?

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

### Cost and Quality of Care at Retail Clinics

**Key point:** *Quality scores at retail clinics rivaled those at urgent care centers, physician offices, and EDs.*

**Citation:** Mehrotra A, Liu H, Adams JL, et al. Comparing costs and quality of care at retail clinics with that of other medical settings for 3 common illnesses. *Ann Intern Med.* 2009;151(5):321-328.

Professional organizations have raised concerns about the quality of care that is delivered at store-based retail clinics. Using claims data from a Minnesota health insurer, investigators searched for episodes of initial care for pharyngitis, otitis media, and urinary tract infections; they identified 2,100 episodes that occurred in retail clinics and matched them with 13,070 episodes that occurred in urgent care centers, physician offices, or emergency departments (EDs). In addition to location and ailment, cases were matched by age, sex, comorbidities, and income.

Aggregate quality scores (proportion that met indicators specific for each condition) were similar for retail clinics, physician offices, and urgent care centers (64%, 61%, and 63%, respectively) and lower at EDs (55%). Urine cultures for high-risk patients were ordered less often at retail clinics than in other settings (30% vs. 55%–58%). Costs per episode

(health plan reimbursements plus copayments) were lower for retail clinics (\$110) than for physician offices (\$166), urgent care centers (\$156), and EDs (\$570).

Many physicians smirk when they hear about care that is delivered at a retail clinic or at a freestanding “doc-in-the-box.” This study won’t settle questions about quality of care in such settings, in part because all settings scored low and measures were obtained exclusively from claims data. But, clearly, these services have arisen in response to perceived needs.

[Published in *J Watch Gen Med*, September 17, 2009—Richard Saitz, MD, MPH, FACP, FASAM.]■

### Do Corticosteroids and Antiviral Agents Have Benefits for Patients with Bell Palsy?

**Key point:** *New evidence has emerged regarding the use of corticosteroids and antiviral agents in Bell palsy.*

**Citation:** Almeida JR, Khabori MA, Guyatt GH, et al. Combined corticosteroid and antiviral treatment for bell palsy: A systematic review and meta-analysis. *JAMA.* 2009;302(9):985-993.

Eligible studies were randomized controlled trials comparing treatment with either corticosteroids or antiviral agents with a control and measuring at least one of the following outcomes: unsatisfactory facial recovery (four months), unsatisfactory short-term recovery (six week to less than four months), synkinesis and autonomic dysfunction, or adverse effects. Eighteen trials involving 2,786 patients were eligible.

Regression analysis identified a synergistic effect when



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## ABSTRACTS IN URGENT CARE

corticosteroids and antiviral agents were administered in combination compared with alone.

Meta-analysis using a random-effects model showed corticosteroids alone were associated with:

- a reduced risk of unsatisfactory recover
- a reduced risk of synkinesis and autonomic dysfunction
- no increase in adverse effects.

In addition:

- Antiviral agents alone were not associated with a reduced risk of unsatisfactory recovery.
- When combined with antiviral agents, corticosteroids were associated with greater benefit than antiviral agents alone.
- When combined with corticosteroids, antiviral agents were associated with greater risk reduction of borderline significance compared with corticosteroids alone. ■

### Simple Abscesses—Can We Poke without the Pack?

*Key point: Packing is not necessary.*

Citations: Taira BR, Singer AJ, Thode HC Jr., et al. National epidemiology of cutaneous abscesses. *J Emerg Med.* 2009;27:289-292.

O'Malley GF, Dominici P, Giraldo P, et al. Routine packing of simple cutaneous abscesses is painful and probably unnecessary. *Acad Emerg Med.* 2009;16:470-473.

Visits to the emergency department for cutaneous abscesses more than doubled between 1996 and 2005. Incision and drainage are the mainstay of treatment. The authors of these articles challenge the common wisdom that packing is critical to the care and healing of cutaneous abscesses.

Researchers conducted a prospective, randomized, single-blinded study of 48 adult subjects presenting to a single emergency department with simple cutaneous abscesses. All adult patients with cutaneous abscesses on the trunk or extremities that required I&D were eligible. Exclusion criteria included abscesses greater than 5 cm in diameter, pregnancy, comorbid medical conditions with possible immunosuppression including diabetes, HIV, malignancy, and chronic steroid use, as well as abscesses on other areas of the body and head, and a sulfa allergy.

Standard incision, drainage, and irrigation were performed on each abscess. Subjects were then randomized to packing with ¼ inch plain gauze or no packing. Pain scores were measured in the ED using a standard 100-point visual analog scale (VAS); subjects were asked to record their VAS pain score twice daily until they were seen in a return visit in 48 hours. All subjects were prescribed trimethoprim-sulfamethoxazole (TMP-SMX), ibuprofen, and oxycodone/acetaminophen.

A physician blinded to the study examined each wound at



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the 48-hour visit and determined the need for further intervention and measured wound erythema, induration, and fluctuance. Measurements were repeated by a second, similarly blinded physician. All patients were contacted by phone 10-15 days after the initial visit to determine if their abscesses had required additional interventions.

Patients were randomized to the packing group (n=23) or the non-packed group (n=25). Only 34 subjects (66%) returned for the 48-hour follow-up visit. Thirteen were from the non-packed group and 21 from the packed group. Four of the patients in the packed group and five of the patients in the non-packed group required intervention at follow-up.

Ten of the 11 patients in the non-packed group who did not return for follow-up and were contacted by phone reported that they did not think the abscess required re-evaluation and that they were pain free. Only one of the three patients in the packed group who did not follow up was reached and reported moderate pain but did not return to the ED.

There was no difference between the groups in pre-procedural pain scores. Subjects in the packed group reported higher pain scores in both the immediate post-procedural period and at the 48-hour follow up visit. There was no significant difference in the amount of ibuprofen taken, but patients in the packing group took a mean of 3.1 narcotic pain pills, compared with a mean of 0.91 pills in the non-packed group.

Given the prevalence of community acquired methicillin-resistant *Staph aureus*, it is unlikely that we will see a reduction in the prevalence of cutaneous abscesses. However, if the evidence bears out, elimination of packing of simple abscesses will save time and money and reduce patient discomfort. ■

*A note on dehydration*

A complication of any of the URTIs in children, and sometimes adults, is dehydration. Fever and other mechanisms can increase insensible fluid loss, and malaise and sore throat can decrease fluid intake. Discuss fever control, analgesia, and appropriate oral hydration with each patient; occasionally providing intravenous fluid rehydration may be necessary.

**Patient Satisfaction**

There is no evidence that patient satisfaction is related to getting an antibiotic prescription for a URTI. In addition, data show that clinicians are not able to determine whether any particular patient expects such a prescription or not.

Studies do link patients' satisfaction to their receiving discussions of their diagnoses, as well as attention to alleviation of their symptoms.

Several years ago, the concept of a delayed or "safety net" prescription was introduced. This strategy involved giving a patient an antibiotic prescription, along with instructions to wait for several days of no improvement before filling and beginning to take it. This approach was shown in several studies to be safe, to reduce antibiotic use, and to be satisfactory to patients. However, a recent review<sup>12</sup> combining many studies showed that prescribing no antibiotic, rather than giving a safety net prescription, resulted in similar clinical and patient satisfaction outcomes, assuming clinicians felt that it was safe not to prescribe antibiotics for a URTI.

**Conclusion**

Antibiotic prescribing has a direct impact on the development of antimicrobial resistance. URTIs are a common chief complaint in urgent care practice, and the tendency to overprescribe antibiotics exists. A variety of guidelines and data from the medical literature can assure the clinician that antibiotics are not necessary for the majority of uncomplicated URTIs in most patients. ■

**References**

1. Albrich WC, Monnet DL, Harbarth S. Antibiotic selection pressure and resistance in *Streptococcus pneumoniae* and *Streptococcus pyogenes*. *Emerg Infect Dis*. 2004;10(3):514-517.
2. Roumie CL, Halasa NB, Grijalva CG, et al. Trends in antibiotic prescribing for adults in the United States—1995 to 2002. *J Gen Intern Med*. 2005;20(8):697-702.
3. McCaig LF, Besser RE, Hughes JM. Antimicrobial drug prescription in ambulatory care settings, United States, 1992-2000. *Emerg Infect Dis*. 2003;9(4):432-437.
4. Gregory DA. Pertussis: A disease affecting all ages. *Am Fam Physician* 2006;74:420-426.
5. Piccirillo JF. Acute bacterial sinusitis. *N Engl J Med*. 2004;351:902-910.
6. Parrillo SJ, Parrillo CV. Pediatrics, Kawasaki disease. eMedicine.com. Last updated: April 15, 2008. Accessed July 1, 2009. Available at: [www.emedicine.com/emerg/TOPIC811.HTM](http://www.emedicine.com/emerg/TOPIC811.HTM).
7. Ahovuo-Saloranta A, Borisenko OV, Kovanen N, et al. Antibiotics for acute maxillary sinusitis. *Cochrane Database of Syst Rev*. 2008;Apr 16;(2):CD000243. Last updated: May 29, 2007. Accessed July 1, 2009. Available at: [www.cochrane.org/reviews/en/ab000243.html](http://www.cochrane.org/reviews/en/ab000243.html).
8. Petersen I, Johnson AM, Islam A, et al. Protective effect of antibiotics against serious complications of common respiratory tract infections: retrospective cohort study with the UK General Practice Research Database. *BMJ*. 2007;335(7627):982.
9. Coleman C, Moore M. Decongestants and antihistamines for acute otitis media in children. *Cochrane Database of Syst Rev*. 2008 Jul 16;(3):CD001727. Update of: *Cochrane Database Syst Rev*. 2004;(3):CD001727. Accessed July 1, 2009. Available at: [www.cochrane.org/reviews/en/ab001727.html](http://www.cochrane.org/reviews/en/ab001727.html).
10. Zalmanovici A, Yaphe J. Steroids for acute sinusitis. *Cochrane Database of Syst Rev*. 2007;Apr 18;(2):CD005149. Last updated: April 18, 2007. Accessed July 1, 2009. Available at: [www.cochrane.org/reviews/en/ab005149.html](http://www.cochrane.org/reviews/en/ab005149.html).
11. Young J, DeSutter A, Merenstein D, et al. Antibiotics for adults with clinically diagnosed acute rhinosinusitis: A meta-analysis of individual patient data. *Lancet*. 2008;371(9616):908-914.
12. Spurling GKP, Del Mar C, Dooley L, et al. Delayed antibiotics for respiratory infections. *Cochrane Database of Syst Rev*. 2007;Jul 18(3);CD004417. Last updated: May 03, 2007. Accessed July 1, 2009. Available at: [www.cochrane.org/reviews/en/ab004417.html](http://www.cochrane.org/reviews/en/ab004417.html).