ABSTRACTS IN URGENT CARE

- Clinical decision tool for testicular torsion
- Walgreens' Take Care Clinics
- Morning-sickness pill
- Chest pain in the ER
- GI complications of NSAIDs

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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.

Clinical Decision Tool Identifies Boys at Low Risk of Testicular Torsion

Key point: No child with a normal testicular lie, age <11 years, and absence of nausea or vomiting had torsion.

Citation: Shah MI, Chantal CA, Mendez DR. Prospective pilot derivation of a decision tool for children at low risk for testicular torsion. *Acad Emerg Med.* 2013;20(3): 271-278.

To develop a clinical decision tool for identifying children at low risk for testicular torsion, investigators prospectively enrolled patients <21 years of age presenting to a pediatric emergency department with scrotal pain for ≤72 hours. History and physical exam findings used to derive the decision tool were recorded before diagnostic imaging or surgical evaluation.

Of 228 patients (mean age, 10 years) who were evaluated for testicular pain over a 32-month period, 21 (9%) were diagnosed with testicular torsion. Among 222 patients (97%) who underwent Doppler ultrasound, the two most common pathological diagnoses were torsion of the appendix testis (23%) and epididymitis/orchitis (20%). Among the 6 patients who did not undergo ultrasound, 1 had immediate surgical exploration and was diagnosed with torsion, and 5 had no evidence of torsion at follow-up.

All 21 patients with testicular torsion were identified by three factors: abnormal testicular lie (strongly associated with absence of a cremasteric reflex), age 11 to 21 years, and nausea or vomiting. The absence of all three factors identified 92 patients (40%) as low risk for torsion, with a negative predictive value of 100%, sensitivity of 100%, specificity of 44%, and positive predictive value of 15%. Use of this rule in the study sample would have resulted in a 59% reduction in ultrasound testing.

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Walgreens Clinics to Start Managing Chronic Conditions

Key point: Walgreens' in-store Take Care Clinics, run by nurse practitioners and physician assistants, will now offer chronic disease management at over 330 locations.

Citation: http://news.walgreens.com/article_display.cfm?article_id=5730

Walgreens' in-store Take Care Clinics, run by nurse practitioners and physician assistants, will now offer chronic disease management at over 330 locations, the company announced on Thursday.

The new services will include diagnosis, treatment, and monitoring for chronic conditions, such as hypertension, diabetes, and hypercholesterolemia. In addition, new preventive health services will be offered; for example, screenings or blood tests may be ordered based on a patient's age, sex, and family history.

The Associated Press notes concern among physicians that such services "can disrupt their relationships with patients and lead to fragmented care." The chief medical officer of the Take Care Clinics counters that the clinics are "filling a niche for patients who need access" to primary care, especially given the growing shortage of primary care doctors and difficulty find-

ing a provider who accepts Medicare or Medicaid. ■

Morning-Sickness Pill Bendectin Back on the Market with a New Name

Key point: The combination of doxylamine succinate and pyridoxine hydrochloride (in the past called Bendectin) has once again been approved to treat nausea and vomiting in pregnancy.

Citation: http://www.fda.gov/NewsEvents/Newsroom/PressAnnouncements/ucm347087.htm

The combination of doxylamine succinate and pyridoxine hydrochloride has once again been approved to treat nausea and vomiting in pregnancy, the FDA has announced. The drug, to be marketed as Diclegis, was previously sold under the name Bendectin.

Bendectin was voluntarily pulled from the market in 1983 over concerns about birth defects; those concerns later proved to be unfounded.

The new approval was based on a randomized trial in which Diclegis outperformed placebo among some 260 pregnant women. In addition, says the FDA, epidemiologic studies show that the drug does not harm the fetus.

Severe sleepiness can occur with Diclegis, so patients should not drive, operate heavy machinery, or perform other activities that require mental alertness while taking the drug.

Clinicians should reassess a patient's continued need for Diclegis as the pregnancy progresses, the FDA advises. ■

Chest Pain: What Happens After the Emergency Department?

Key point: Patients who follow up with cardiologists do best.

Citation: Czarnecki A, Chong A, Lee DS, et al. Association between physician follow-up and outcomes of care after chest pain assessment in high-risk patients. *Circulation*. 2013;127(13):1386-1394.

Researchers examined patterns of follow-up care and outcomes in high-risk patients with chest pain who presented to Ontario emergency departments (EDs) from 2004 to 2010. High risk was defined as having a prior diagnosis of cardiovascular disease, diabetes, or both. The primary outcome was a composite of all-cause death and hospitalization for myocardial infarction within 1 year after the index visit.

Of nearly 57,000 patients, 17% followed up with a cardiologist (with or without a visit to primary care) within 30 days after ED discharge, 57% followed up with a primary care practitioner only, and 25% did not have a visit to a physician recorded. After adjustment for clinical, demographic, and hospital characteristics, the cardiologist group had a significantly lower hazard ratio for the composite outcome (HR, 0.79; P<0.001) than the no–follow-up group and the PCP-only group (HR, 0.85; P<0.001). PCP-only follow-up was significantly beneficial compared to no follow-up (HR, 0.93; P<0.023). Patients seen by cardiologists underwent more testing and received more evidence-based therapies within 100 days after discharge.

Published in *J Watch Emerg Med.* April 19, 2013 — J. Stephen Bohan, MD, MS, FACP, FACEP. ■

Gastrointestinal Complications from NSAID Use in Clinical Practice

Key point: In a PROBE trial of 8067 patients with osteoarthritis, 1.3% using celecoxib experienced GI complications compared with 2.4% using a nonselective NSAID.

Citation: Cryer B, Li C, Simon LS, et al. GI-REASONS: A novel 6-month, prospective, randomized, open-label, blinded endpoint (PROBE) trial. *Am J Gastroenterol*. 2013;108(3):392-400.

Multiple studies have demonstrated the association between nonsteroidal anti-inflammatory drug (NSAID) use and gastrointestinal (GI) complications. Results of these studies might be difficult to apply to clinical practice because of uncontrolled confounding in observational studies or a rigid protocol in randomized trials. Now, to apply the rigor of a randomized, controlled design and reflect the real-life variability of clinical practice, researchers conducted an industry-sponsored, prospective, randomized, open-label, blinded endpoint (PROBE) trial to compare the incidence of GI complications with use of celecoxib versus a nonselective nonsteroidal anti-inflammatory drug (nsNSAID) in 8067 patients with osteoarthritis from 783 clinics in the U.S.

Patients were stratified by *Helicobacter pylori* infection status and randomized to receive either celecoxib or an nsNSAID of the treating physician's choice for 6 months. Patients taking aspirin were excluded. Adjustments in drug doses and the use of gastroprotective agents were allowed. The primary endpoint of clinically significant upper or lower GI complications was determined by a blinded adjudication panel.

More GI complications occurred in the nsNSAID group than in the celecoxib group (2.4% vs. 1.3%; odds ratio, 1.82; 95% confidence interval, 1.31–2.55). The vast majority of complications were occult GI bleeding (44 of 54 in the celecoxib group and 75 of 98 in the nsNSAID group). Upper GI bleeding occurred in only 2 patients — both in the nsNSAID group. Fewer moderate-to-severe abdominal symptoms were reported in the celecoxib versus nsNSAID group (2.3% vs. 3.4%; *P*=0.004). Frequencies of other complications were similar, including cardiovascular events. The dropout rate was approximately 35% in both groups.

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