ABSTRACTS IN URGENT CARE

- Guidelines for Treating Diarrheal Disease
- Length of Wait Defined for Testing for Cure of Gonorrhea
- Testing for Syphilis Is Beneficial for Individuals at High Risk
- Oral and Intravenous Routes for Antibiotics Are Equally as Effective in Community-Acquired Pneumonia
- Monitoring Programs Help Cut Down on Opioid Prescribing
- Infants' Fecal Microbiota May Affect Their Risk of Contracting Bronchiolitis
- Fluoroquinolone Antibiotics Can Have Disabling Adverse Effects
- New Guidelines Are Available for Non-Work-Related Prophylaxis for Human Immunodeficiency Virus

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Each month the Urgent Care College of Physicians (UCCOP) provides a handful of abstracts from or related to urgent care practices or practitioners. Sean M. McNeeley, MD, leads this effort.

The American College of Gastroenterology Publishes New Guidelines for Treating Diarrheal Disease

Key point: New guidelines on treating diarrheal disease are available from the American College of Gastroenterology.

Citation: Riddle MS, DuPont HL, Connor BA. ACG clinical guideline: diagnosis, treatment, and prevention of acute diarrheal infections in adults. *Am J Gastroenterol*. 2016;111: 602–622.

The authors of this report note that the Centers for Disease Control and Prevention reports 47.8 million cases of diarrhea a year. Acute diarrhea is defined as an increased number of loose stools for less than 14 days. The guidelines do not discuss *Clostridium difficile* infections. The article is comprehensive and a good read for all acute-care providers. Plus, Figure 1 has a good decision tree for diagnosis and treatment. Items applicable to the urgent care setting include the following:

- Stool cultures should be obtained for more than 7 days during outbreaks of dysentery or in moderate to severe disease.
- Assays for fecal leukocytes are imprecise and not likely beneficial.
- Traveler's diarrhea should be treated for 3 days with quinolone, or for 5 days if the presence of *Shigella* is likely.
- Most community-acquired diarrhea is viral in origin. ■

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Length of Wait Defined for Testing for Cure of Gonorrhea

Key point: Tests of cure with the new RNA and DNA probes must wait 1 week and 2 weeks, respectively.

Citation: Wind CM, Schim van der Loeff MF, Unemo M, et al. Test of cure for anogenital gonorrhoea using modern RNA-based and DNA-based nucleic acid amplification tests: a prospective cohort study. *Clin Infect Dis*. 2016;62:1348–1355.

Recently most laboratories have been using the newer DNA and RNA probes to detect gonorrhea. The authors of this report note that there is no recent research into how long to wait after treatment to test for cure. They performed a study in the Netherlands of both RNA and DNA probes of patients treated for gonorrhea and in need of testing for cure. Patients were tested daily for 28 days after treatment with 500 mg of ceftriaxone. RNA probe findings were negative at 7 days, and DNA probe findings were negative at 14 days. This is good information for urgent care

providers to provide to patients. Even if you do not test them for cure, you must advise your patients about how long to wait to be tested by their primary-care provider. ■

Testing for Syphilis Is Beneficial for Individuals at High Risk

Key point: Consider testing for syphilis in high-risk patients.

Citation: US Preventive Services Task Force (USPSTF). Screening for Syphilis Infection in Nonpregnant Adults and Adolescents: US Preventive Services Task Force Recommendation Statement. *JAMA*. 2016;315:2321–2327.

According to the author of this report, there were 20,000 cases of syphilis in the United States in 2015. The article discusses the U.S. Preventive Services Task Force recommendations on screening asymptomatic individuals at high risk for infection and concludes that there is minimal risk and significant benefit in screening asymptomatic patients at high risk for syphilis. High-risk patients include men who have sex with other men, people living with the human immunodeficiency virus, those with a history of incarceration, sex workers, those from specific locations, those of specific races or ethnicities, and men younger than 29 years. For urgent care providers, it makes sense to know who fits into high-risk groups in their area and to consider testing those who present for potentially related issues such as possible sexually transmitted infections. If your urgent care center does not perform these tests, at least recommending them to patients would be beneficial. ■

Oral and Intravenous Routes for Antibiotics Are Equally as Effective in Community-Acquired Pneumonia

Key point: Route of antibiotic administration does not seem important for fluoroquinolone in community-acquired pneumonia.

Citation: Belforti RK, Lagu T, Haessler S, et al. Association between initial route of fluoroquinolone administration and outcomes in patients hospitalized for community-acquired pneumonia. *Clin Infect Dis*. 2016;63:1–9.

Many studies have shown that quinolones have equivalent bioavailability whether given orally or intravenously. This study retrospectively reviewed data on antibiotic administration route for 34,200 patients admitted to hospitals for community-acquired pneumonia; 2205 received antibiotics orally. Antibiotics administered included levofloxacin and moxifloxacin. The authors found no differences between outcomes for the two administration routes. Although this was an inpatient study, its findings do confirm similar outcomes for oral and intravenous quinolone in the treatment of pneumonia. For the urgent care provider, this is assurance that for patients who recover at home, oral treatment is not inferior to intravenous treatment. ■

Monitoring Programs Help Cut Down on Opioid Prescribing

Key point: Opioid-monitoring programs work.

Citation: Bao Y, Pan Y, Taylor A, et al. Prescription drug monitoring programs are associated with sustained reductions in opioid prescribing by physicians. *Health Aff (Millwood)*. 2016;35:1045–1051.

The authors of this article assessed prescription-monitoring systems and their effectiveness in lowering the number of opioid prescriptions. The data are from 24 U.S. states, from 2001 to 2010. The authors noted a 30% decrease in the number of schedule II opioids prescribed once the monitoring systems went live, and this effect was maintained for years 2 and 3. Considering that there are 19,000 opioid-related overdoses each year in the United States, such a decrease will likely translate into fewer negative health outcomes. Use of these systems when available is mandated by some states, and their use should be considered best practice in the remainder. ■

Infants' Fecal Microbiota May Affect Their Risk of Contracting Bronchiolitis

Key point: Infants with certain fecal microbiota may be more susceptible to bronchiolitis.

Citation: Hasegawa K, Linnemann RW, Mansbach JM, et al. The fecal microbiota profile and bronchiolitis in infants. *Pediatrics*. 2016;138:e20160218.

This case-control study compared the fecal microbiota of 40 infants hospitalized with bronchiolitis to 115 age-matched healthy infants. The authors found four stool patterns. The incidence of bronchiolitis was lowest in those with *Enterobacter*- or *Veillonella*-dominant stools, whereas those with *Bacteroides*-dominant stools were at significantly greater risk of bronchiolitis (odds ratio, 4.59). However, it still must be proven that changing the gut flora is necessary. ■

Fluoroquinolone Antibiotics Can Have Disabling Adverse Effects

Key point: Reconsider prescribing that fluoroquinolone.

Citation: U.S. Food and Drug Administration. FDA Drug Safety Communication: FDA advises restricting fluoroquinolone antibiotic use for certain uncomplicated infections; warns about disabling side effects that can occur together. Silver Spring, MD: U.S. Food and Drug Administration [published 2016 May 12; updated 2016 June 7; cited 2016 August 7]. Available from: http://www.fda.gov/drugs/drugsafety/ucm500143.htm

Normally this column covers original research, but this communication from the U.S. Food and Drug Administration is very

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important and should not be missed. Considering the range of antibiotics that can be prescribed and the potential for spontaneous resolution of many of the illnesses seen in urgent care, careful consideration of antibiotic choice is yet again urged. Diagnoses included in the warning include sinusitis, bronchitis, and uncomplicated urinary tract infections. Serious adverse effects involving the tendons, muscles, joints, nerves, and central nervous system are the concern with fluoroquinolone. ■

New Guidelines Are Available for Non-Work-Related Prophylaxis for Human Immunodeficiency Virus

Key point: New guidelines are available for prophylaxis for exposure to human immunodeficiency virus outside of work.

Citation: Announcement. Updated guidelines for antiretroviral postexposure prophylaxis after sexual, injection-drug use, or other nonoccupational exposure to HIV—United States, 2016. *MMWR Morb Mortal Wkly Rep*. 2016;65:458.

The new guidelines from the Centers for Disease Control and Prevention are focused on the prevention of infection with human immunodeficiency virus (HIV) in patients with a single nonoccupational exposure to blood, genital secretions, or other potentially infectious body fluids that might contain HIV. The entire document is 92 pages long. Highlights include the following:

- Postexposure prophylaxis (PEP) should be provided if the patient's HIV test findings are negative or if their HIV status is unavailable and exposure to a known HIV risk is significant.
- PEP after 72 hours of exposure is not recommended.
- Treatment is a 28-day course of a three-drug regimen.

Because these directives can change, it is recommended that health-care providers always check the latest information. For the urgent care provider, these guidelines are an excellent resource on how to treat patients with potential HIV exposure. ■