ABSTRACTS IN URGENT CARE

- How Much Time with the Physician is 'Enough' Time?
- Pursuing Responsible Use of Antibiotics
- Cranberry Capsules Not Helpful in Preventing UTI
- Gout Guidelines Hold Tips for Urgent Care Providers
- Multidrug-Resistant *Candida auris*
- Variability in Assessment of Full-Term Febrile Babies
- Comparing CV Safety and Endpoints of Three NSAIDs
- Prices for Generic Heart Failure Drugs Vary Wildly

SEAN M. McNEELEY, MD

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.

How Much Time with the Physician is "Enough" Time?

Key point: Length of time with a provider may not be related to patient experience.

Citation: Elmore N, Burt J, Abel G, et al. Investigating the relationship between consultation length and patient experience: a cross-sectional study in primary care. *Br J Gen Pract*. 2016;66(653):e896-e903.

This study documented the length of stay for 529 patients who were seen by a primary care physician. Patients were then asked to fill out a survey about their visit to indicate how they perceived the experience. Questions included whether the physician "gave you enough time," "listened to you," and "took your problems seriously." There was no relationship between actual visit time and the patient's answers. For the acute care provider, understanding that perception—not actual time spent—is most important to the patient is a good start. Understanding how the perception of "enough" time spent needs to be further reviewed. ■

Sean M. McNeeley, MD, is an urgent care practitioner and Network Medical Director at University Hospitals of Cleveland, home of the first fellowship in urgent care medicine. Dr. McNeeley is a board member of UCAOA and UCCOP. He also sits on the *JUCM* editorial board.

"Compliance with antibiotic guidelines was found to be just 52%."

Responsible Use of Antibiotics: Try Starting with Otitis Media, Sinusitis, and Strep Throat

Key point: Widespread compliance with antibiotic guidelines is still a way off.

Citation: Hersh AL, Fleming-Dutra KE, Shapiro DJ, et al. Frequency of first-line antibiotic selection among U.S. ambulatory care visits for otitis media, sinusitis, and pharyngitis. *JAMA Intern Med*. 2016;176(12):1870-1872.

The National Action Plan set a goal of 50% reduction in inappropriate antibiotic prescriptions. Some sources classify 30% of prescriptions as unnecessary in upper respiratory infections. "Inappropriate" prescriptions also include selection of incorrect antibiotics, such as broad-spectrum instead of a more narrow-spectrum choice. First-line antibiotics for otitis media and sinusitis include amoxicillin or amoxicillin with clavulanate; for strep throat, penicillin or amoxicillin is recommended as first line. Overall compliance in this study was found to be only 52%. The highest compliance was found in otitis media in children. Urgent care providers would be well advised to consider good compliance with guidelines for at least these three common

"The new ACP gout guidelines include several new recommendations that pertain closely to the urgent care setting."

infections to be a good first step toward proper antibiotic stewardship. ■

Cranberry Capsules Not Helpful in Preventing UTI in Older Women—But What About Cranberry Juice?

Key point: Cranberry capsules may not be helpful in preventing UTI, but more study needs to be done on possible benefits of cranberry juice.

Citation: Juthani-Mehta M, Van Ness PH, Bianco L, et al. Effect of cranberry capsules on bacteriuria plus pyuria among older women in nursing homes. *JAMA*. 2016;316 (18):1879-1887.

In this double blind, placebo-controlled study, 187 female nursing home residents were given either two cranberry capsule per day or placebo with the hopes of reducing the number of urinary tract infections. Unfortunately, there was no difference in abnormal urine results or incidence of UTI between the groups. For the acute care provider, this is disappointing; however, there may be a difference between capsules and actual cranberry juice. Further studies would be helpful in this arena. ■

New Gout Guidelines Hold Tips for the Urgent Care Provider

Key point: Updated ACP recommendations include advice applicable in urgent care.

Citation: Qaseem A, Harris RP, Forciea MA. Management of acute and recurrent gout: a clinical practice guideline from the American College of Physicians. *Ann Intern Med*. November 1, 2016. [Epub ahead of print]

Among the American College of Physicians' new recommendations for treatment of gout are several that pertain closely to urgent care. Specifically, the guidance recommends using steroids, NSAIDs, or colchicine to treat acute gout; using low-dose colchicine when that agent is chosen in order to avoid side effects; and not starting urate-lowering medication after just one or infrequent episodes of acute gout. Although there is nothing earth-shattering here, these are clear principles applicable to the acute care provider. ■

Study of Multidrug-Resistant *Candida auris* Underscores the Need for Responsible Prescribing

Key point: Even fungal disease is becoming resistant.

Citation: Vallabhaneni S, Kallen A, Tsay S, et al. Investigation of the first seven reported cases of *Candida auris*, a globally emerging invasive, multidrug-resistant fungus—United States, May 2013–August 2016. *MMWR Morb Mortal Wkly Rep*. 2016;65(44):1234–1237.

Multiple articles dealing with antibiotic overuse and bacterial-resistant infections have been reviewed in this column. This article discusses *Candida auris*, an emerging fungus that can cause invasive infections that has now been cultured in the United States and appears to be one more infection to be concerned about. Most infections are related to exposure from South America and South Asia. Further, most patients with infections in this study were also immunocompromised. For the urgent care provider, the message here is to be aware of another potentially serious infection and to use care with both antibiotics and antifungals. ■

Assessment and Treatment of Full-Term Febrile Infants Varies by Several Factors

Key point: Ordering of complete work-ups for fever diminishes as babies age.

Citation: Greenhow TL, Hung YY, Pantell RH. Management and outcomes of previously healthy, full-term, febrile infants ages 7 to 90 days. *Pediatrics*. November 1, 2016. [Epub ahead of print]

This three-year study reviewed electronic medical records for all full-term infants ages 7 to 90 days presenting with fever. The incident rate of fever was 14.4/100,000. Complete work-up percentages varied by age: 7-28 days, 59%; 29-60 days, 25%: and just 5% for those age 61-90 days. Of interest, a small percentage returned with a diagnosis of UTI. There were no returns for bacteremia or meningitis. Although the urgent care setting rarely cares for patients age 7 to 90 days with febrile illnesses, knowing current practices will help guide parents who present with children with fever in this age group. ■

Comparing Cardiovascular Safety and Endpoints with Celecoxib vs Ibuprofen and Naproxen

Key point: Celecoxib proves not inferior to ibuprofen and naproxen.

"Advise patients that the price of generic digoxin, lisinopril, and carvedilol can be up to 50 times higher from one pharmacy to the next."

Citation: Nissen SE, Yeomans ND, Solomon DH, et al. Cardiovascular safety of celecoxib, naproxen, or ibuprofen for arthritis. *N Engl J Med*. November 13, 2016. [Epub ahead of print]

This study of >24,000 patients reviews the cardiovascular safety of celecoxib compared with ibuprofen or naproxen. Patients were randomized to receive one of the medications and were followed for about 2 years. Celecoxib was not inferior to the others considering cardiovascular endpoints. It did seem to have fewer issues with GI bleeding and renal damage. Although placebo was not in the comparison here, it appears celecoxib is at least equivalent to ibuprofen or naproxen and perhaps better in terms of GI bleed and renal safety. For the urgent care provider who believes a medication like these is needed, this study may provide valuable insights. Obviously, cost is significantly different among these products, as well, and should be discussed. ■

Patients Should Shop Around When Filling Prescriptions for Heart Failure Meds

Key point: Generic prices for heart failure drugs vary wildly.

Citation: Hauptman PJ, Goff ZD, Vidic A, et al. Variability in retail pricing of generic drugs for heart failure. *JAMA Intern Med*. November 15, 2016. [Epub ahead of print]

This study compares the generic prices of digoxin, lisinopril, and carvedilol in a single 55 zip code area. Depending on which individual retail pharmacy was visited, there could be a 50-fold difference in price for the same drug—and no explanation of the cost difference. The implications for this are significant. For the urgent care physician, recognizing the effect price can have on patient compliance and satisfaction with treatment can be quite frustrating. The only way to resolve this is to be sure patients understand where they get their prescription has a large effect on the price of the medication. Other studies with prescriptions like amoxicillin would be very interesting here. ■