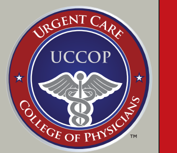

ABSTRACTS IN URGENT CARE

- Clindamycin to Reduce Resistance to Group A Strep?
- No Recommendation to Screen for Herpes
- When Do You Stop Monitoring Arrhythmias?
- Assessing Overtreatment of Children
- Update: Guidelines for Earwax Impaction
- Use Cardiac Risk Scores with Caution
- Stinging Insect Hypersensitivity
- Looking at Epi for Older Patients?

SEAN M. McNEELEY, MD and GLENN HARNETT, 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.

Clindamycin Reduces Resistance to Group A Strep

Key point: Another use for clindamycin.

Citation: Andreoni F, Zurcher C, Tamutzer A, et al. Clindamycin affects group A streptococcus virulence factors and improves clinical outcome. *J Infect Dis*. 2017;215(2):269-277.

Necrotizing fasciitis is a life-threatening infection not frequently seen in the urgent care center, though it does occur. This article from the Infectious Diseases Society of America discusses the importance of adding clindamycin to the treatment regimen. No good quality evidence was present before this article proving the effect, but it was surmised that clindamycin reduces the resistance factors of group A step. From their results, the authors recommend clindamycin be used early and at a high dose. For the urgent care provider, this is good information—and one more instance where a medication is used to help reduce resistance. ■

No Recommendation to Screen for Herpes

Key point: Potential harm outweighs benefits of serologic screening for genital herpes.

Citation: U.S. Preventive Services Task Force. Serologic screening for genital herpes infection: U.S. Preventive Services Task Force recommendation statement. *JAMA*. 2016;316(23): 2525-2530.

Prevalence of herpes may be as high as one in six persons in the United States. There remains no cure for herpes, although there are several antivirals that may decrease symptoms when taken in time. In this article, the U.S. Preventive Services Task Force reviews the accuracy, benefits, and potential harm of serological testing for herpes. They note a low specificity and high false positive rate. Due to the absence of a cure, along with the anxiety and concerns created by a false positive, they concluded the potential benefit was less than the harm. A false negative could also create problems, as well. This article can help the urgent care provider in discussion when patients ask for this type of testing. Even a true positive does not define the location of the virus. ■

When Do You Stop Monitoring Arrhythmias?

Key point: A rule to help predict which arrhythmias should be addressed.

Citation: Syed S, Gatien M, Perry JJ, et al. Prospective validation of a clinical decision rule to identify patients presenting to the emergency department with chest pain who can safely be removed from cardiac monitoring. *CMAJ*. 2017;189(4):E139-E145.

Sean M. McNeeley, MD, is an urgent care practitioner and Network Medical Director at University Hospitals Cleveland Medical Center, 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. **Glenn Harnett, MD,** is principal of the Resistance Consulting Group in Mountain Brook, AL.

Although many cardiac monitors are available in the United States, they are still a limited commodity. Concerns of arrhythmia in patients with chest pain and potential AC are a reason for monitoring. Almost 800 patients were evaluated with an endpoint of arrhythmia requiring intervention in the ED or within 8 hours of leaving. The rule proved 100% sensitive but only 36% specific. The rule used was the Ottawa chest pain cardiac monitoring rule. The rule required the patient to be chest pain-free and to have a normal or nonspecific EKG. Although not directly applicable to most urgent care center treatment, knowing which patients are less likely to have an arrhythmia needing treatment is helpful. This rule predicts that. ■

The Dangers of Overdiagnosing and Overtreating Children

Key point: There's potential harm in providing more care than necessary to children.

Citation: Coon ER, Young PC, Quinonez RA, et al. Update on pediatric overuse. *Pediatrics*. 2017;139(2).

This article reviews for overdiagnosis, overtreatment, and overutilization of medical care for children. Overdiagnosis included hypoxemia in children with bronchiolitis and skull fractures in children with minor head injuries. Overtreatment included concerns for long-term antibiotics in pneumonia; excessively long treatment of osteomyelitis with IV antibiotics; antidepressants for adolescents; and nebulized hypertonic saline for bronchiolitis, which may not be effective. And overutilization included CT scans for potential appendicitis. For the urgent care provider, several of these issues may be pertinent. Overdiagnosis of hypoxemia in children with bronchiolitis may cause unnecessary admission. The same surgeon might be present if skull fractures are overdiagnosed; minor head treatment, as well. Use of antibiotics, particularly intravenous when oral might be just as effective, could also be applicable. Finally, avoiding CT scans when possible to rule out appendicitis is also an area potentially applicable to urgent care. The overall idea of considering what physicians and other providers are ordering or performing that may be unnecessary on a population basis is important to ponder. ■

An Update of Guidelines for Earwax Impaction

Key point: Treat only symptomatic patients.

Citation: Schwartz SR, Magit AE, Rosenfeld RM, et al. Clinical practice guideline (update): earwax (cerumen impaction). *Otolaryngol Head Neck Surg*. 2017;156(1 Suppl):S1-S29.

This update to the American Academy of Otolaryngology-Head and Neck Surgery Foundation's 2008 Cerumen Impaction Guidelines provides updates on the management and prevention of cerumen impaction. They reiterated that clinicians should only treat cerumen impaction when it causes symptoms or prevents needed assessment of the ear. Injury to the ear canal in the manual removal of cerumen should be avoided. Guidelines continue to strongly suggest that patients at risk for, or with a history of cerumen impaction, should not insert any foreign body into the ear canals (including cotton swabs) as they may cause injury and worsen impactions. Lastly, the committee strongly recommends against the practice of ear candling/coning for the treatment of cerumen impaction as it may cause serious injury and there is little to no evidence that it is effective. For the urgent care provider, recommended treatment methods are the use of cerumenolytic agents, irrigation, and manual removal using instrumentation such as ear curettes. If urgent care management is unsuccessful, patients should be referred to a specialist. ■

> *"The authors strongly suggest that repeat testing of cardiac troponin levels should be considered, even in low risk patients."*

Comparing Missed AMI Among Various Risk Prediction Scores

Key point: Use cardiac risk scores with caution.

Citation: Singer AJ, Than MP, Smith S, et al. Missed myocardial infarctions in ED patients prospectively categorized as low risk by established risk scores. *Am J Emerg Med*. 2017; Jan. 5. [Epub ahead of print]

This study compared the rate of missed AMI in ED patients prospectively categorized as low risk via the use of various cardiac risk prediction scores (ie, TIMI, HEART, GRACE, EDACS), as well as unstructured clinical impression. Unstructured clinical impression was defined as an estimate by the attending ED physician of the likelihood of acute MI as low, medium, or high based on clinical gestalt and either with or without two cardiac troponin (cTn) levels. When using the recommended low-risk cutoff points of the predictive tools, the results indicated that a TIMI score of 0 or a low unstructured clinical impression (combined with two negative cTn levels) were the only methods that did not misclassify any AMI patients. None of the other predictive tools were sensitive enough to reduce the risk of AMI to an acceptable missed rate, generally considered to be <1%. The authors strongly suggest that repeat testing of cardiac troponin levels should be considered, even in low risk patients. For the urgent care provider, cardiac risk scores should continue to be

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"The data support current recommendations for the administration of IM epi to anaphylactic patients in the elderly population."

used cautiously when determining the safety of discharging patients with suspected AMI or acute coronary syndrome. ■

Update on Treating Stinging Insect Hypersensitivity

Key point: In severe reactions, prescribe epinephrine auto-injector and refer to an allergist.

Citation: Golden DB, Demain J, Freeman T, et al. Stinging insect hypersensitivity: a practice parameter update 2016. *Ann Allergy Asthma Immunol*. 2017;118(1):28-54.

This practice parameter update suggests that most insect stings cause mild local reactions, for which no specific treatment is usually required. Oral antihistamines and oral analgesics may reduce pain and itching associated with mild cutaneous reactions. Many physicians use oral corticosteroids for larger, local reactions, although definitive proof of efficacy through controlled studies is lacking. Antibiotics are not indicated unless there is a clear indication of secondary infection–eg, fever, chills, or sweats. Imported fire ants are common in the southeastern U.S. and their sting produces a characteristic sterile pustule. Patients with severe or systemic reactions should be prescribed an epinephrine auto-injector and instructed on its proper use. Patients should also consider obtaining and carrying a medical identification bracelet or necklace. These patients should be referred to an allergist for skin/lab testing and consideration of venom immunotherapy. ■

Why Are Older Patients Less Likely to Receive Epi?

Key point: IM epinephrine (epi) appears safe in elderly patients.

Citation: Kawano T, Scheuermeyer FX, Stentstrom R, et al. Epinephrine use in older patients with anaphylaxis: clinical outcomes and cardiovascular complications. *Resuscitation*. 2017;112:53-58.

This study examined the proportions of older (defined in this study as ≥50 years of age) and younger patients presenting with severe allergic reaction/anaphylaxis who subsequently received treatment with epi. Results revealed that 36% of the elderly group received epi, compared with 60.8% of the younger group. This appears to support the authors' hypothesis that older patients would be less likely to receive epi due to clinician concerns. The study also measured the rate of cardiovascular complications following IV or IM epi administration for anaphylaxis, including ventricular fibrillation/tachycardia, atrial fibrillation/flutter, acute stroke, elevated troponin, or new ischemic EKG changes. IM epi appeared to be safe in older patients with anaphylaxis, but cardiovascular complications were more common in those receiving IV epi. For the urgent care provider, the data support current recommendations for the administration of IM epi to anaphylactic patients in the elderly population. ■