

URGENT CARING



COLLEGE OF
URGENT CARE
MEDICINE

OFFICIAL NEWSLETTER OF THE COLLEGE OF URGENT CARE MEDICINE

CUCM PRESIDENT - Jasmeet Bhogal, MD



Advanced training in urgent care --

A while back I wrote about the need to develop urgent care as a specialty. One of the key steps required to get on this path is the presence of advanced training programs in urgent care. Urgent care sits in a unique position where our providers are a blend of physicians, physician assistants and nurse practitioners. Currently, all these categories have a significant presence in urgent care. Urgent care training programs can be developed to provide advanced training to each of these categories. The overarching goal is to inspire excellence and advance the specialty of urgent care.

Developing training programs is not easy. There are many aspects that need to be considered, many questions that need to be answered. Some examples are:

1. How many trainees to begin with?
2. What is the optimal duration the training program?
3. How to create a feasible financial structure that is sustainable?
4. What will the curriculum look like?
5. How to strike a balance between clinical hours and didactic training?

These are just some of the questions that urgent care centers need to answer when thinking of developing and starting fellowship programs. The College has been serving as a accrediting body for advanced urgent care urgent care training programs for almost two years now. Currently, there is one training program that is accredited with the College. We are working with other programs as well and hope to engage more organizations.

The accreditation criteria have been developed while keeping the urgent care paradigm in mind. These criteria include details about site where the training will be conducted; the curriculum that will be followed; who will be part of the faculty; and finally, what will the competency evaluation structure look like. These questions form the basic structure of our current accreditation requirements. Each of these come with their own set of details.

It is important that urgent care leaders and organizations begin to think about the idea of developing advanced training programs in urgent care. These training programs will help us improve the quality of patient care by training urgent care providers in aspects of clinical care that are unique to urgent care. We need to inspire excellence amongst our teams and also advance the specialty. The development of advanced training programs is a critical step in this direction. If you are thinking about starting such a program within your urgent care organization, please feel free to contact us. You can contact me directly at drjsbhogal@gmail.com.

EDITOR'S CORNER - Sean M McNeeley, MD, FCUCM

Well the trends continues, Dr. Bhogal continues to use almost the entire first page. This month we have several new items from the college that we plan on making recurrent. (see next page). We also recently welcomed all our physician, physician assistant and nurse practitioners who are UCA members to our college. Glad to have you here. (continued page 2)



(Continued from page 1)

Our two new features are Best Practices and Urgent Updates. Best practice are a description of new or changed practice patterns or evidence laid out in an easy to read condensed format. Urgent update are smaller bits of information that help us better care for our patient. We look forward to your thoughts on these new offerings.

I have also added two tools created by our Clinical Response Task Force to help decide which patients are eligible for monoclonal antibody treatment for coronavirus infection. Just like our tests and vaccines this treatment is currently approved under emergency use authorization and how it fits into care has uncertainty. The provider considering this must make an individual decision based on the patient presenting to them and know risks and benefits of therapy. These tools are to assist the provider in recognizing who the EUA covers, not to recommend for or against this therapy for any specific patient. These two tools are attached as addenda. Finally if you have been enjoying the CUCM Listserv please note the following:

CUCM Listserv Update

Beginning on April 2, 2021, access to the COVID-19 ListServ will transition to a UCA members-only benefit

Those who are not members will be removed from the subscribers list and will not receive emails from the group.

Based on the email address listed for you in the ListServ program you are not currently a UCA member. Don't worry, it might be that your email address isn't the same in the ListServ as it is on your membership profile.

Please send an email to Jami Kral – jkral@ucaoa.org if your email addresses are different, you aren't a member but would like to join, or if you are unsure of your membership status. We will get it sorted out and make sure you remain in the list of member subscribers.

Thank you for your participation and support of the UCA community!

Finally please note:

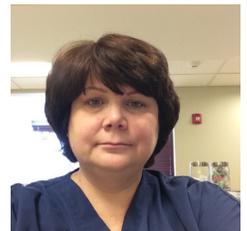
The College of Urgent Care Medicine is collaborating with the American College of Obstetrics and Gynecology (ACOG) to raise awareness about maternal health. ACOG provided an webinar last week on "**Maternal Cardiac Conditions: Addressing a Leading Cause of Pregnancy-Related Death**". It is now available on demand online.

Contact Dr.McNeeley: sean.mcneeley@uhhospitals.org

Dermatology Challenge: The Burn That's Getting Bigger

Tracey Q. Davidoff, MD, FCUCM

A 55-year-old female presents to the urgent care center with a chief complaint of "infected burn". The patient states 2 weeks earlier, she had burned her right thumb on a hot pot. The patient states the burn was very small but had a blister that broke. 5 days later, she went to her primary care doctor who prescribed ciprofloxacin and an over-the-counter topical antibiotic for a presumed infection. The patient states the original swelling, pain, and blister has resolved, but now there is an ulcerated area that is 3-4 times larger than the original burn. It seems to be getting larger every day. There is no pain, but the wound itches and is weeping serous fluid. She has completed the ciprofloxacin and is still caring for her wound by washing with soap and water and applying the antibiotic ointment and a bandage. Consider the photo below:



The most likely diagnosis of this patient's conditions is:

- A. Herpetic whitlow
- B. Wound infection or cellulitis
- C. Tinea versicolor
- D. Contact dermatitis due to neomycin
- E. Normal healing of a second-degree burn

Answer: D, contact dermatitis due to neomycin.

Herpetic whitlow is a skin infection on the finger that develops when a patient touches a herpes simplex lesion on another part of the body. The virus usually enters through a small break in the skin. It then causes a blistering lesion that appears similar to oral or genital herpes. It is frequently mistaken for a bacterial infection. Wound infection or cellulitis is unlikely in this case as there is no pain, swelling, or erythema around the edges of the wound. Tinea infection in this area would not likely be a "wet" infection and would more likely be dry with an appearance more like ringworm. Wet infections are more common in intertriginous areas such as between the toes or under skin folds. Normal healing of a second-degree burn would be a possible diagnosis but is not supported by the patient's history. This patient stated the burn was much smaller and did not become this large until repeated application of the antibiotic ointment. This is often the case when the patient feels the infection is getting worse; they apply more and more ointment, which makes the appearance of the wound worse and worse. When asked what ointment she had used, it was in fact a neomycin containing product.

Neomycin can cause a contact reaction in patients in two ways, allergic contact dermatitis and non-allergic irritant reaction. Non-allergic irritant reaction is felt to be more common. This has been studied with patch testing. The Mayo Clinic Department of Dermatology has reported that the incidence of neomycin allergic contact dermatitis is around 8%. Patients may also be sensitive to other ingredients in the ointment and not the antibiotic at all.

Many dermatologists and burn specialists are now recommending against the use of topical antibiotics due to the risk of local reaction and the minimal decrease in infection rate when topical antibiotics are used. White petroleum jelly provides the same protection to the wound keeping the epithelium moist and providing a protective barrier. Use of topical antibiotics when unnecessary may also contribute to antibiotic resistance.

Strange but True; Alpha-gal Allergy

Tracey Q. Davidoff, MD, FCUCM

A patient presented to my clinic several weeks ago for an orthopedic injury. On his health history form he stated that he was allergic to "mammals". Although it really didn't impact clinical decision making in this patient, I just had to know more about this apparent allergy. How can a human, who is a mammal, be allergic to mammals?

The patient told me he was bitten by a tick which rendered him allergic to mammals. I'm pretty sure I laughed out loud. He said he knew it sounded strange and that he usually got looks like the one I was apparently giving him, and when I had a few minutes, I should look up alpha-gal syndrome. Alpha-gal? I suddenly had visions of Gal Gadot playing Wonder Woman dancing in my head.

So I turned to my trusty computer, and asked it about Alpha-gal. It did not disappoint. Most food allergies are to protein molecules. However, carbohydrates can also act as allergens. The carbohydrate moiety galactose-alpha-1,3-galactose, or alpha-gal is abundantly found in the cells and tissues of all mammals except primates. Patients with this allergy are especially sensitive to beef, pork, and lamb, as well as organ meats, gelatin, and milk.

Patients often report having multiple tick bites prior to the onset of allergic symptoms. The lone star tick is most frequently implicated in the southeastern US, but ticks in Australia, Spain, Germany, Japan, and Sweden have also been implicated. It is thought that the ticks feast on a mammal containing alpha-gal which is then regurgitated into the host. The host ultimately develops sensitization and subsequently allergy to the alpha-gal.

This allergy is an IgE mediated immune response and includes urticaria, angioedema, or anaphylaxis, but unlike
(CME Continues on page 4)

traditional IgE mediated responses, the reactions does not occur in minutes, but 3-6 hours after ingestion. This often makes it difficult to associate the food to the reaction. Treatment is the same as any other allergic reaction with histamine blockers, steroids, epinephrine, and fluid resuscitation as indicated.

Reference:

<https://www.cdc.gov/ticks/alpha-gal/index.html>

<https://www.mayoclinic.org/diseases-conditions/alpha-gal-syndrome/symptoms-causes/syc-20428608>

https://www.uptodate.com/contents/allergy-to-meats?search=alpha%20gal%20allergy&source=search_result&selectedTitle=1~26&usage_type=default&display_rank=1#H11265746

Urgent Updates

Cesar Mora Jaramillo, MD



BALANCING THE RISKS AND BENEFITS OF BENZODIAZEPINES

US Food and Drug Administration (FDA) announced in September of 2020 an update to the boxed warning on all benzodiazepines, recommending clinicians to consider the serious risks of abuse, addiction, physical dependence, and withdrawal reactions when prescribing these medications. In addition to the revised boxed warning, the FDA is also modifying the detailed prescribing information. Urgent Care Clinicians must be aware of the risks as fewer benzodiazepine prescriptions are needed. JAMA Viewpoint reviews the relative benefits and risks of benzodiazepines, discusses potential consequences of the FDA amendments, and describes a potential approach for the rational prescribing of benzodiazepines. Full Article: JAMA

PUBLIC HEALTH RECOMMENDATIONS FOR VACCINATED PERSONS:

Currently authorized vaccines in the United States are highly effective at protecting vaccinated people against symptomatic and severe COVID-19. Additionally, evidence suggests that fully vaccinated people are less likely to have asymptomatic infection and potentially less likely to transmit SARS-CoV-2 to others. CDC published guidelines for individuals fully vaccinated and exposure to someone suspected or confirmed COVID-19. Fully vaccinated people might, visit with other fully vaccinated people indoors without wearing masks or physical distancing, visit with unvaccinated people from a single household who are at low risk for severe COVID-19 disease indoors without wearing masks or physical distancing, and refrain from quarantine and testing following a known exposure if asymptomatic. Full Access: CDC

THE HEAR HER CAMPAIGN

The CDC launched a National Communication Campaign that brings attention to maternal morbidity and mortality in the United States. Campaign seeks to raise awareness of potentially life-threatening warning signs during and in the year after pregnancy and encourage the people supporting pregnant and postpartum women to really listen and take action when she expresses concerns. Clinicians working in Urgent Care frequently care for pregnant and postpartum patients. Hence, recognizing the urgent maternal warning signs and obtaining an accurate and timely diagnosis can save lives. Campaign materials are designed to enhance communication between pregnant and postpartum women, their support systems, and their healthcare providers. Full Access: CDC

INAPPROPRIATE MAGNETIC RESONANCE IMAGING IS ASSOCIATED WITH NEGATIVE OUTCOMES

Clinicians often order MRI for acute uncomplicated nonspecific lower back pain. In a large retrospective cohort study of > 400,000 Electronic Medical Records were reviewed. Findings showed that MRI in early clinical course was associated with potential harm due to excess surgery and opioid use. This study was shared by NEJM Journal on January 12. Full Article: Journal of General Internal Medicine

INTERIM GUIDANCE FOR COVID-19 VACCINATION IN CHILDREN AND ADOLESCENTS

On February 2nd, 2021 The American Association of Pediatrics published Interim Guidance for SARS-Covid-2 vaccination. The AAP recommends that anyone 16 years of age and older who meets criteria in phased implementation groups, as recommended by the ACIP, receive the COVID-19 vaccine. The CDC, through the ACIP, has identified priority groups for phased vaccination. States and communities continue to develop and to modify vaccine distribution based on this guidance, reflecting unique community situations. Full Access: AAP



Best Practice Summary of the College of Urgent Care Medicine

Update of CDC Guidelines of the treatment of Gonococcal Infection December 2020

Date Reviewed	2/10/2021
Subject	Treatment of Gonococcal Infection
Patient Population	Adult male and female
Rationale	Updated guidelines on the recommended treatment of gonococcal infections of the cervix, urethra, pharynx, or rectum required due to antibiotic stewardship and antibiotic resistance
Introduction	In December 2020 the CDC updated the recommended treatment of gonorrhea based on the increasing concern of azithromycin resistance. This is replacing the recommendation from 2010 which recommended ceftriaxone 250mg IM and azithromycin 1 gm orally. This earlier recommendation was based on the strategy that azithromycin would not only treat concomitant infections with other organisms such as Chlamydia trachomatis but would also prevent ceftriaxone resistance. Increasing concerns of antibiotic stewardship and overall increasing resistance to azithromycin, coupled with the relatively low incidence of gonococcal resistance to ceftriaxone has led to a change in these recommendations. Gonococcal resistance to ceftriaxone remains quite low, therefore leading to the new recommendations of single drug treatment of gonorrhea.
Evidence based guideline with strength of evidence (if available)	Confirmed or suspected uncomplicated urogenital, rectal, or pharyngeal gonorrhea should be treated with ceftriaxone 500 mg IM. Patients who weigh > 150 kg or 300 lbs. should be treated with 1 gm of ceftriaxone. If chlamydial infection has not been excluded, doxycycline 100 mg orally twice daily for 7 days should also be prescribed. Cefixime 800 mg orally once is an acceptable, but not as effective alternative to ceftriaxone. Patients who cannot take cephalosporins due to allergy or other concerns may be treated with gentamycin 240 mg IM AND azithromycin 2 gm orally. Test of cure is only required in cases of gonococcal pharyngitis.
Discussion	Urgent care clinics are often at the forefront of evaluating and treating patients with confirmed or suspected STD's. It is important that the urgent care provider stay up to date on the latest recommendations on the treatment of these diseases. These recommendations were made by the CDC

	based on review and data from the CDC's Gonococcal Isolate Surveillance Project, a literature review of over 2,200 abstracts and journal articles, STD conferences, and the NIH clinical trials website. Both government and non-governmental representatives made up a panel that reviewed this data and made recommendations that ultimately became these new guidelines.
Summary	As of December 2020, the recommended treatment of patients with confirmed or suspected urogenital, anal, or pharyngeal gonorrhea is ceftriaxone 500 mg IM. If chlamydia has not been excluded, doxycycline 100 mg twice daily for 7 days should also be prescribed. Patients > 150 kg should receive 1 gm ceftriaxone IM.
References	https://www.cdc.gov/mmwr/volumes/69/wr/mm6950a6.htm?s_cid=mm6950a6_w https://www.cdc.gov/std/treatment-guidelines/evidence.htm
Reviewers	Tracey Q. Davidoff, MD, FCUCM, Cesar Mora Jaramillo, MD
Attachments (flow charts, graphics, tables, etc.)	None

Continuing Medical Education (CME)

Target Audience

This CME activity is intended for medical professionals who practice medicine in the on-demand space including urgent care, retail medicine and other similar venues. These providers may include physicians, nurse practitioners, and physician assistants.

Designation Statement

The Urgent Care Association (UCA) designates this enduring material activity for a maximum of *1 AMA PRA Category 1 Credit(s)*™. Physicians should claim credits only commensurate with the extent of their participation in the activity. Credits may be claimed for one year from the date of release of this issue.

CME Objectives

- 1. Provide updates on the diagnosis and treatment of clinical conditions commonly managed by on-demand providers**
- 2. Alert on-demand providers to potential unusual cases that may present to them**
- 3. Utilize tips and tricks to improve patient care in the on-demand space**

Accreditation Statement

This activity has been planned and implemented in accordance with the accreditation requirement and policies of the Accreditation Council for Continuing Medical Education (ACCME) through the joint providership of the Urgent Care Association and the College of Urgent Care Medicine. UCA is accredited by the ACCME to provide continuing medical education for physicians.

CME Credit Instructions

Once you have read the article, please log into your UCA profile. Once you are logged in go to *Manage My Account -> My Library*. Now you will be logged into the UCA Online Education Library. Go to *Course Catalog -> Clinical -> Urgent Caring CME*. Click on the Urgent Caring edition for this month. You will need to score 60% on the Quiz and complete the Survey to obtain credit. Your certificate will show up under *My Library -> Credits*. Please email education@ucaoa.org with questions.

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Disclaimer

Medical practice and knowledge is constantly evolving and changing. This information is peer-reviewed but should not be your only source. Providers of care should use discretion when applying knowledge to any individual patient.

CME Questions*:

1. Which of the following is TRUE:

- a. Antibiotic ointment is necessary for all wounds to prevent infection
- b. Herpetic whitlow is reactivation of the chicken pox virus on the finger
- c. Neomycin may cause a non-allergic irritant reaction on the skin
- d. Tinea infections on the finger frequently appear wet
- e. The use of topical antibiotics does not contribute to antibiotic resistance

2. Which of the following are TRUE about alpha-gal allergy?

- a. Patients are allergic to the protein found in fowl
- b. Patients frequently develop an IgE mediated reaction immediately after eating food containing alpha-gal
- c. Traditional treatments of allergic reactions such as antihistamines and steroids do not work
- d. Unlike traditional allergies which are caused by proteins, this allergy is to a carbohydrate
- e. Only the lone star tick has been implicated in this phenomenon

3. What is the newer proper dose for gonorrhea treatment in patients under 150kg?

- a. ceftriaxone 125mg
- b. ceftriaxone 250mg
- c. ceftriaxone 500mg
- d. ceftriaxone 1000mg

4. Early MRI in back injury was associated with

- a. Excess surgery
- b. Increased length of symptoms
- c. Worsening pain scores
- d. Difficulty sleeping

Answers from last month

1. What is the most prevalent form of COVID-19 transmission in newborns from presumptive or positive SARS-COV-2 mothers?

- a. Intrauterine transmission
- b. **Through respiratory droplets**
- c. Through breastfeeding
- d. Intrapartum transmission

2. Select the correct statement in terms of testing for neonates born of presumptive or COVID-19 positive mothers.

- a. Testing is recommended for all symptomatic neonates only
- b. Testing is recommended for all asymptomatic neonates at > 72 hours
- c. **Testing is recommended at 24 hours in symptomatic and asymptomatic neonates regardless of mother's symptoms.**
- d. Testing should be repeated at 48 hours in all neonates

3. All of the following are true about a ruptured globe injury EXCEPT:

- a. The eye should be protected from further trauma with metal shield or other device
- b. Visual acuity may be decreased
- c. The diagnosis should be confirmed by using fluorescein
- c. **The affected eye may have an irregular pupil**
- e. Penetrating objects such as pencils are more common in children, whereas projectiles are more common in adults

4. RNA Virus mutations may alter which of the following:

- a. Transmission
- b. Pathogenesis
- c. Virulence
- d. **All of the above**

ABOUT US



COLLEGE OF
URGENT CARE
MEDICINE

The College of Urgent Care Medicine (CUCM), formally known as the Urgent Care College of Physicians (UCCOP), was founded by physicians from the Urgent Care Association (UCA) to provide a clinician voice for the specialty. CUCM and UCA continue to work closely to advance the clinical practice of urgent care medicine. In 2016 the UCCOP board voted to include physician assistants and nurse practitioners as members. Thus in early 2017 the decision to change our name was made.

Mission Statement

We are urgent care clinicians inspiring excellence in patient care and advancing the specialty through education, advocacy, and research.

COLLEGE OF URGENT CARE MEDICINE



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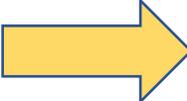
ELIGIBILITY CRITERIA FOR MAB INFUSION

Eligibility Requirements for all:

- Positive PCR/NAA or Antigen SARS-CoV-2 test (not antibody test); and,
- ≥ 12 years of age and weight ≥ 40 kg
- Within 10 days of the onset of symptoms AND criteria as outlined below:

HIGH RISK for progressing to severe COVID-19 as defined by ANY ONE of the following:

- AGE ≥ 65 years old
- BMI ≥ 35
- Chronic kidney disease
- Diabetes mellitus
- Immunocompromising condition
- Currently receiving immunosuppressive treatment

• Age $\geq 12-17$ & have 

• Age ≥ 55 and have 

Age 12-17 years old AND any one of the following

- BMI $\geq 85^{\text{th}}$ percentile for age and gender using the CDC's growth charts*; or,
- Sickle Cell Disease; or,
- Congenital or acquired heart disease; or,
- Neurodevelopmental disorders; or,
- A medical-related technological dependence (e.g., tracheostomy, gastrostomy, positive pressure ventilation unrelated to COVID); or,
- Asthma, RAD or chronic respiratory disease that requires daily medicine for control

Age ≥ 55 years old AND any one of the following:

- Cardiovascular disease; or,
- Hypertension; or,
- Chronic obstructive pulmonary disease/ other chronic respiratory disease

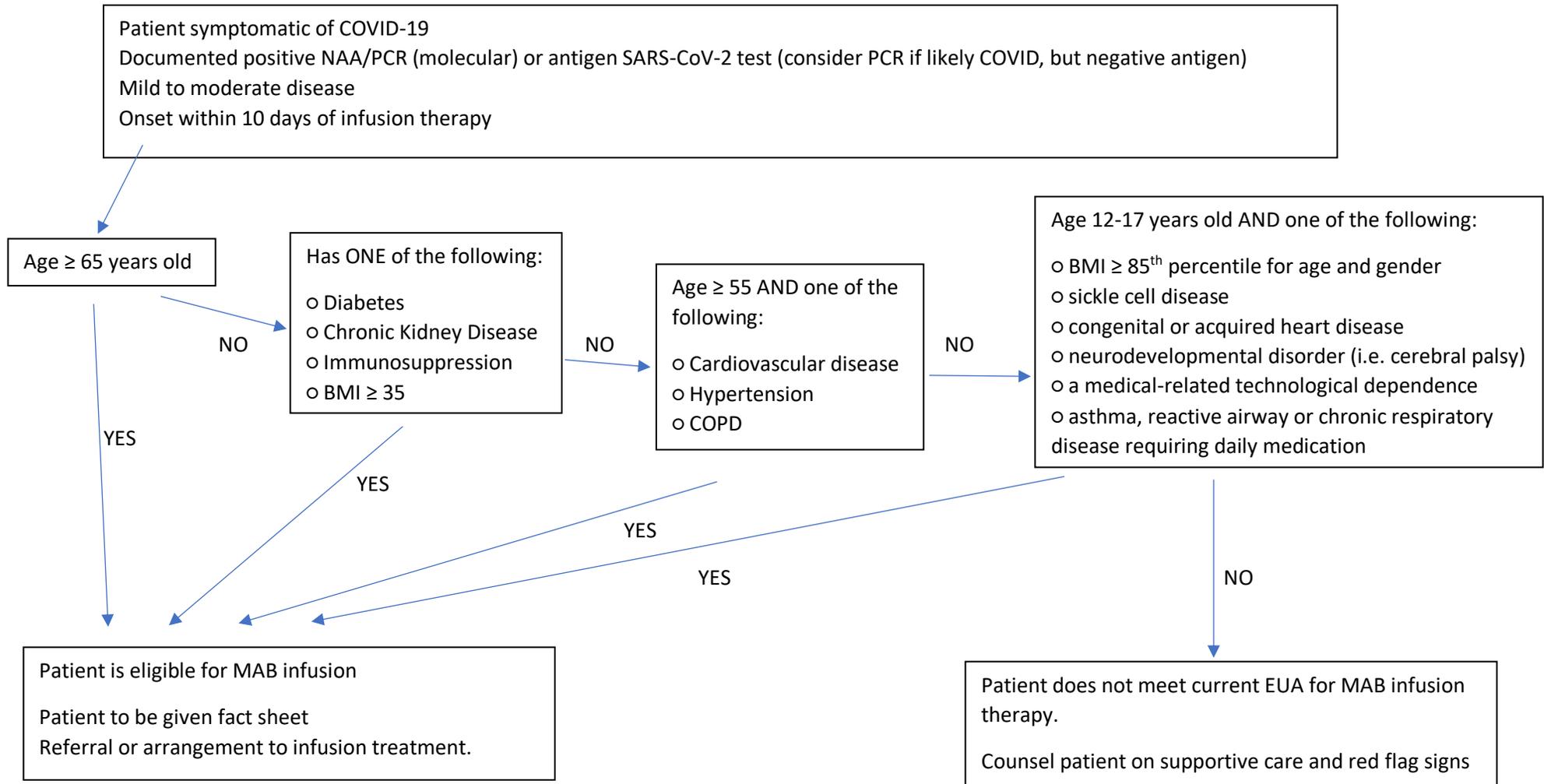
Exclusion Criteria:

- Hospitalized patients due to COVID-19
- Patient who requires oxygen therapy due to COVID-19
- Patient who require an increase in baseline oxygen flow due to COVID-19

*[Growth Charts - Homepage \(cdc.gov\)](https://www.cdc.gov/growthcharts/)

Flowchart for determination of MAB infusion eligibility

NOTE: MAB infusion is an Emergency Use Authorized (EUA) therapy for patients weighing ≥ 40 kg and aged 12 years and older. MAB cannot be prescribed "off label." Do not use if patient is has severe disease, is hospitalized or on supplemental oxygen therapy beyond baseline.



Fact sheet:

[bamlanivimab-eua-factsheet-hcp.pdf \(lilly.com\)](https://www.lilly.com/healthcare/medicines/vaccines-and-biologics/casirivimab-and-imdevimab-for-covid-19/fact-sheet-for-patients-parents-and-caregivers-emergency-use-authorization-eua-of-casirivimab-and-imdevimab-for-covid-19.pdf)

[Fact Sheet for Patients, Parents, and Caregivers: Emergency Use Authorization \(EUA\) of casirivimab and imdevimab for COVID-19 \(fda.gov\)](https://www.fda.gov/oc/2020/08/fact-sheet-for-patients-parents-and-caregivers-emergency-use-authorization-eua-of-casirivimab-and-imdevimab-for-covid-19)