

URGENT CARING



COLLEGE OF
URGENT CARE
MEDICINE

OFFICIAL NEWSLETTER OF THE COLLEGE OF URGENT CARE MEDICINE

CUCM PRESIDENT - Jasmeet Bhogal, MD



The Tale of Two Worlds

Recently, the CDC has updated its masking guidelines for people who are fully vaccinated. According to these new guidelines, fully vaccinated people can resume activities without wearing masks or physically distancing, except where required by federal, state, local, tribal, or territorial laws, rules and regulations, including local business and workplace guidance. Fully vaccinated people can also resume domestic travel and refrain from testing before or after or self-quarantine after travel.

Data from the CDC states that now 37% of the total US population is fully vaccinated. While this is mostly the adult population, there is now even more good news from the pediatric front. FDA has now approved the Pfizer-BioNTech COVID-19 vaccine to be given to children age 12 to 15 years of age. In addition to this, as of May 14, 2021, the current 7-day moving average of daily new cases decreased by 23.6% compared to the previous 7 days. The 7-day moving average for hospitalizations also showed a decline by 12.4%, the 7-day moving average for deaths decreased by 10.3% as well.

National vaccination efforts coupled with decrease cases of COVID-19 are great news for everyone. Now with children starting to get vaccinated, the goal is to get middle school students vaccinated so that they can return to school in the fall. All this brings us closer to returning to a sense of normalcy, and hopefully, ending the pandemic. Businesses are starting to open, people are starting to return to their jobs. We are starting to return to normal.

While we start to return to normalcy here in the United States, there is a completely different picture that is being seen in India. With a new double mutant COVID-19, B1.617 circulating, India is seeing one of the worst outbreaks of COVID-19 since the beginning of 2019, and one of the worst healthcare crisis it has seen in decades. India has so far registered 25 million total cases, with more than 270,000 deaths. These are official numbers, the unofficial numbers are speculated to be much higher. These numbers keep increasing on a daily basis. With only 11% of the population vaccinated against COVID-19, the country suffers to get basic healthcare supplies such as hospital beds, oxygen to patients who are sick, struggling and dying.

The B1.617 variant is now considered a "variant of concern" by the WHO. While studies are being conducted to better understand this variant, there is concern that this variant has increased transmissibility and also possibly can evade the immunity conferred by a previous COVID-19 infection.

The healthcare crisis that is currently unfolding in India is a sobering reminder of the devastation that the COVID-19 variants can bring with them. As we begin our efforts to return to normalcy here in the United States, we need to be aware of what is happening in the rest of the world can travel to us as well. Caution is required as we take steps towards normalcy. While we have taken the right steps and are on our way to overcoming this pandemic, there are still parts of the world that are struggling and that need help. We need to respect this virus and the devastation that it can bring.

Stay safe my friends.

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

Well the trends continues, Dr. Bhogal continues to use almost the entire first page. At least it's always good information. This month we continue our new elements and other features. Last week we celebrated nurses' week. A fact I did not remember is the week is always the same dates May 6 -12. May 12 is Florence Nightingale's birthday.

(Continued next page)

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Celebrating our nurses both those who have worked to be providers as well as those who assist us in caring for our patients is very important. Without them our patients would be so much worse off.



This month we feature a best practices from Dr Davidoff related to influenza care. It seems a little strange timing in May, but we all but missed the influenza season last year and as the country opens up after vaccinations and measures to combat Coronavirus are less used some of us expect a return to a busy influenza seasons. For our patients we hope this does not occur but being prepared is always a good choice.

Another great article by Dr. Jaramillo discusses antibiotic resistance and the importance of antibiotic stewardship that may have been somewhat lost during the peak of the pandemic has also been included. In a world where it has been all Coronavirus all the time we can't fail to remember our other measures of quality and good stewardship of the medications were are lucky to have in our toolbox.

Last month our Listserv Live series featured a discussion of vital signs and how we should be looking at these in the era after Coronavirus changed the world in many ways. As part of this presentation a sample vitals signs policy was presented. I am including it at the end of this month edition for your review and incorporation to you policies

On a more editorial note, this year has been crazy for all of us and I realize we missed two issues of *Urgent Caring* already. We appreciate your understanding and expect things to return to mid month releases the remainder of the year. Thanks for all you do for our patients and see you next month.

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Use of Antibiotics

Cesar Mora Jaramillo, MD

Antibiotic use contributes to antibiotic resistance and is associated with adverse events, including Clostridium difficile infections. According to Centers for Disease Control and Prevention (CDC, more than 2.8 million antibiotic-resistant infections occur in the U.S. each year, and more than 35,000 people die as a result. In addition, 223,900 cases of Clostridioides difficile occurred in 2017 and at least 12,800 people died. The estimated national cost to treat infections caused by six multidrug-resistant germs can be more than \$4.6 billion annually.¹



Clinicians must be aware that antimicrobial overuse causes adverse events in up to 20% of patients.² Studies and meta-analyses have shown that compared with longer courses of antibiotics, shorter courses show similar clinical outcomes with fewer drug-related adverse event.² This critical information has to be incorporated when deciding if antibiotic prescription is necessary.

Previous studies have demonstrated that in the 2010-2011 period at least 30% of antibiotic prescriptions written in physician offices and EDs were unnecessary.³

Consequently, it is not a surprise that the higher chance of inappropriate prescription occurs at urgent care centers, when compared to retail clinics, emergency department and traditional ambulatory care settings. The study published in JAMA in 2018, found that among visits for antibiotic-inappropriate respiratory diagnoses, antibiotic prescribing was highest in urgent care centers (45.7%).⁴ This is overwhelming and suggest that antibiotic stewardship interventions could help reduce unnecessary antibiotic prescriptions.

Resistance is a documented side effect of prolonged antibiotic use. Urgent Care Clinicians play a key role in antimicrobial stewardship and should limit antibiotic treatment duration when its recommended.

The American College of Physicians provides clinical guidelines for antibiotic length prescription based on the assumption that a patient has the right diagnosis and the right antibiotic prescribed.

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COPD Exacerbation and Acute Uncomplicated Bronchitis	Community-Acquired Pneumonia ¹	Uncomplicated Cystitis and Pyelonephritis	Non purulent Cellulitis
<p>Clinicians should limit antibiotic treatment duration to 5 days.</p> <p>Patients who have clinical signs of a bacterial infection (presence of increased sputum purulence in addition to increased dyspnea, and/or increased sputum volume).</p>	<p>Clinicians should prescribe antibiotics for a minimum of 5 days.</p> <p>Extension of therapy after 5 days of antibiotics should be guided by validated measures of clinical stability, which include resolution of vital sign abnormalities, ability to eat, and normal mentation.</p>	<p>Women with uncomplicated bacterial cystitis: Clinicians should prescribe short-course antibiotics with either nitrofurantoin for 5 days, trimethoprim-sulfamethoxazole for 3 days, or fosfomycin as a single dose.</p> <p>Men and women with uncomplicated pyelonephritis: clinicians should prescribe short-course therapy either with fluoroquinolones (5 to 7 days) or TMP-SMZ (14 days) based on antibiotic susceptibility.</p> <p>clinicians should prescribe short-course therapy either with fluoroquinolones (5 to 7 days) or TMP-SMZ (14 days) based on antibiotic susceptibility.</p>	<p>Clinicians should prescribe a 5- to 6-day course for patients able to self-monitor and who have close follow-up with primary care.</p> <p>Consider extending treatment if the infection has not improved after 5 days.</p>
<p>Treatment may include an aminopenicillin with clavulanic acid, a macrolide, or a tetracycline.</p>	<p>Treatment may include amoxicillin, doxycycline, or a macrolide for healthy adults or a β-lactam with a macrolide or a respiratory fluoroquinolone in patients with comorbidities.</p>	<p>TMP-SMZ should not be used alone as an empirical therapy without culture and susceptibility testing in pyelonephritis.²</p>	<p>Treatment recommendations include a cephalosporin, penicillin, or clindamycin.³</p>

1) CAP is defined as pneumonia in nonimmunocompromised patients presenting with fever, productive cough with purulent sputum, dyspnea, and pleuritic chest pain

2) The increasing prevalence of fluoroquinolone resistance in Enterobacteriaceae requires reevaluation of the efficacy of shorter courses of antibiotic classes other than fluoroquinolones as targeted therapy for pyelonephritis when susceptibility is known

3) Except for patients whose cellulitis is associated with penetrating trauma or who have evidence of MRSA infection elsewhere, nasal colonization with MRSA, injection drug use, or systemic inflammatory response syndrome; in these cases, inclusion of another antimicrobial effective against both MRSA and streptococci is recommended

<https://www.ucaoa.org/Resources/Antibiotic-Stewardship>

REFERENCES:

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2. Lee, Rachael A., et al. "Appropriate Use of Short-Course Antibiotics in Common Infections: Best Practice Advice From the American College of Physicians." *Annals of Internal Medicine*, American College of Physicians, 6 Apr. 2021, www.acpjournals.org/doi/10.7326/M20-7355.
3. Fleming-Dutra KE, Hersh AL, Shapiro DJ, et al. Prevalence of Inappropriate Antibiotic Prescriptions Among US Ambulatory Care Visits, 2010-2011. *JAMA*. 2016;315(17):1864-1873. doi:10.1001/jama.2016.4151
4. Palms DL, Hicks LA, Bartoces M, et al. Comparison of Antibiotic Prescribing in Retail Clinics, Urgent Care Centers, Emergency Departments, and Traditional Ambulatory Care Settings in the United States. *JAMA Intern Med*. 2018;178(9):1267-1269. doi:10.1001/jamainternmed.2018.1632



Abnormal Vital Signs Policy for Urgent Care Centers

Policy:

Patients presenting to urgent care with any complaint should receive a complete set of vital signs, preferably within 15 minutes of arrival. Red Flag vital signs as established in this policy, should be posted at all locations where vital signs are obtained and immediately reported to the on-site provider. The initial readings as well as any repeat reading(s) are to be documented in the patient's medical record.

Scope:

Applicable to urgent care clinics.

Definitions:

N/A

Responsibilities:

It is the responsibility of the site supervisor as well as the Medical Director to ensure the implementation of this policy at all urgent care sites. The individual assigned to triaging and/or rooming the patient is responsible for measuring and documenting the initial set of vital signs and, if abnormal, reporting them to the onsite provider. The provider caring for the patient, in conjunction with the provider's clinical support staff, are responsible for repeating and documenting abnormal vital signs during the process of care.

Exceptions: (If applicable to your organization)

Vital signs are not mandated when the patient is presenting *exclusively* for the following procedures-- not associated with a sick or injury encounter.

For Example:

1. TB Test Reading
2. Urine Drug Screens

NOTE: Complete vital signs may not be possible during COVID-19 testing visits (e.g., administered in the patient's vehicle); however, pulse oximetry is to be performed and recorded.

Procedure:

1. The following vitals are to be performed:
 - a. Patients less than 3 years of age:
 - i. Temperature
 - a) Infants six months of age or younger – Perform a rectal temperature. [NOTE: Do not use mercury thermometers for patients of any age]

- b) Older than six months but less than five years - Axillary temperature.
 - c) Five years and older – Oral temperature. If combative or uncooperative, can do axillary temperature.
 - ii. Heart Rate
 - iii. Respiratory Rate
 - iv. Pulse oximetry
 - v. Height
 - vi. Weight in kilograms or pounds + kilograms
- b. Patients 3 years and older:
- i. Temperature
 - ii. Heart Rate
 - iii. Respiratory Rate
 - iv. Pulse oximetry
 - v. Blood Pressure
 - vi. Height
 - vii. Weight in kilograms or pounds + kilograms

2. Notify provider immediately if:

- a. Patient in obvious distress
- b. Vital signs are outside the following parameters are considered Red Flags:
 [NOTE: the parameters below are guidelines. We encourage medical leadership to review and customize to your own setting, as appropriate)]
 - i. For Adults:

Temperature	102 degrees F or greater
Respiratory Rate	Greater than 22 per minute or difficulty breathing/distress
Pulse	Less than 50 per minute or greater than 110 per minute
Pulse Oximetry	Less than 94% on room air
Blood Pressure	Systolic less than 90mmHg or greater than 180mmHg, Diastolic less than 60mmHg or greater than 120mmHg Pregnancy: Systolic Blood Pressure \geq 140mmHg and/or Diastolic Blood Pressure \geq 90mmHg.

*Reminder: Normal blood pressure for adults is Systolic < 120mmHg and Diastolic <80mmHg.

ii. For Children:

- a) Pulse ox less than 94% room air
- b) Temperature greater than 100.4 degrees F
- c) Heart rate, respiratory rate or blood pressure outside the following parameters:

Age	Respiratory Rate (per minute)	Heart Rate (per minute)	Blood Pressure (Systolic/Diastolic mmHg)
<1 month	30-53	90-205	
1-12 months	30-53	90-180	
1-2 years	22-37	80-140	
3-5 years	20-28	65-120	89-112/46-72
5-9 years	18-25	58-118	97-115/57-76

9-12 years	18-25	58-118	102-120/61-80
12-15 years	12-20	50-100	110-131/64-83

Accurate Blood Pressure measurement

I. Adults:

Key Steps for Proper BP Measurements	Specific Instructions
Step 1: Properly prepare the patient	<ol style="list-style-type: none"> 1. If the initial blood pressure read is abnormal, have the patient relax, sitting in a chair (feet on floor, back supported) for >5 min. 2. Ensure patient has emptied his/her bladder. 3. Neither the patient nor the observer should talk during the rest period or during the measurement. 4. Remove all clothing covering the location of cuff placement. 5. Measurements made while the patient is sitting or lying on an examining table do not fulfill these criteria.
Step 2: Use proper technique for BP measurements	<ol style="list-style-type: none"> 1. Use a BP measurement device that has been validated and ensure that the device is calibrated periodically. 2. Support the patient's arm (e.g., resting on a desk). 3. Position the middle of the cuff on the patient's upper arm at the level of the right atrium (the midpoint of the sternum). 4. Use the correct cuff size, such that the bladder encircles 80% of the arm, and note if a larger- or smaller-than-normal cuff size is used. 5. Either the stethoscope diaphragm or bell may be used for auscultatory readings.
Step 3: Take manual blood pressure read if readings are abnormal with the device.	<ol style="list-style-type: none"> 1. If BP is significantly high by automated device, provider should consider repeating by auscultation (children and adults).
Step 4: Properly document accurate BP readings	<ol style="list-style-type: none"> 1. If applicable, note the time of most recent BP medication taken before measurements.
Step 5: Average the readings	Use an average of ≥ 2 readings obtained on ≥ 2 occasions to estimate the individual's level of BP.
Step 6: Provide BP readings to patient	Provide patients the SBP/DBP readings both verbally and in writing.

Selection Criteria for BP Cuff Size for Measurement of BP in Adults:

Arm Circumference	Usual Cuff Size
22–26 cm	Small adult
27–34 cm	Adult
35–44 cm	Large adult
45–52 cm	Adult thigh

II. Children:

- Correct cuff size depends on arm size. Practically speaking, correct cuff size equals largest cuff that will fit on the upper arm with room below for the stethoscope head.
- BP should be measured in the right arm of a relaxed, seated child.
- BP measurement by auscultation is the gold standard.
- BP by automated device correlates reasonably well with auscultation, with practical advantages of rapid measurement remote from child and elimination of reader error.
- If BP is high by automated device, repeat by auscultation.

References:

- 2017 ACC/AHA/AAPA/ABC/ACPM/AGS/APhA/ASH/ASPC/NMA/PCNA Guideline for the Prevention, Detection, Evaluation, and Management of High Blood Pressure in Adults: A Report of the American College of Cardiology/American Heart Association Task Force on Clinical Practice Guidelines. <https://doi.org/10.1161/HYP.000000000000065>.
- A Pocket Guide to Blood Pressure Measurement in Children - From the National High Blood Pressure Education Program Working Group on High Blood Pressure in Children - From the National High Blood Pressure Education Program Working Group on High Blood Pressure in Children and Adolescents. https://www.nhlbi.nih.gov/files/docs/bp_child_pocket.pdf.



Best Practice Summary of the College of Urgent Care Medicine

Diagnosis and Treatment of Influenza

Date Reviewed	April 2021
Subject	Influenza Testing and Treatment
Patient Population	Adults and Children
Rationale	Though the 2020/21 season was extremely mild likely due to protections used to reduce the impact of COVID-19 disease, influenza historically results in significant morbidity and mortality annually. Many patients are evaluated in the Urgent Care setting. Timely and accurate diagnosis and treatment have been shown to improve outcomes. Avoiding inappropriate prescription of anti-viral medication is also important.
Introduction	Influenza is a contagious respiratory illness caused by the many different strains of the influenza virus. Influenza infects approximately 3 to 11% of the U.S. population annually. The CDC estimates that influenza results in 140,000 – 810,000 hospitalizations and between 12,000 – 61,000 deaths annually since 2010. The exact timing and duration of flu season varies each year, but typically activity increases in October, peaking between December and February, and waning in May. Prompt diagnosis and management may reduce the risk of hospitalization or severe disease for those who are at high risk for complications. (see Table 1)
Evidence based guideline with strength of evidence	o Influenza testing is not required to make a clinical diagnosis of influenza in outpatients with suspected influenza based on symptoms (see Table 2) when seasonal influenza A and

	<p>B viruses are circulating in the local community</p> <ul style="list-style-type: none"> o Antiviral medications should be started promptly in high-risk patients (see Table 1) with suspected influenza with or without a positive influenza test. Antiviral treatment is optional for those who are not at high risk of influenza complications or household contacts of those at high risk. o Patients with influenza should be isolated at home until afebrile for 24 hours off anti-pyretic medications.
<p>Discussion</p>	<p>Diagnosis of influenza: Rapid influenza tests in the ambulatory setting include RIDT (Rapid Influenza Diagnostic Testing) which detect viral proteins and molecular testing which detect genetic material. RIDTs are relatively inexpensive and produce results in approximately 10-15 minutes but are not as accurate as molecular testing. While molecular testing offers the highest sensitivity, these tests may not be readily available in the ambulatory setting.</p> <p>During an influenza outbreak, a negative RIDT is NOT sufficient to rule out influenza in a symptomatic patient. Because of the risk of morbidity and mortality in high-risk patients, treatment should be initiated as soon as possible when influenza is suspected on clinical grounds.</p> <p>Antiviral therapy:</p> <ul style="list-style-type: none"> - baloxavir marboxil (October 24, 2018) - peramivir (December 19, 2014) - oseltamivir (December 14,2000) - zanamivir (July 26,1999) <p>Both baloxavir marboxil and oseltamivir are most commonly recommended for treatment of influenza. Peramivir is given intravenously,</p>

	<p>making it of limited use in the ambulatory setting. Zanamivir is an inhalation powder and may trigger respiratory effects in sensitive groups with pre-existing lung disease. Oseltamivir is a neuraminidase inhibitor while baloxavir marboxil is an endonuclease inhibitor.</p> <p>The dose of oseltamivir for treatment of influenza A and B in patients > age 12: 75 mg PO BID for 5 days. In children dosing is weight based. Under age 1, the dose is 3 mg/kg/dose PO BID for 5 days. Ages 1-12, < 15 kg, 30 mg PO BID for 5 days Ages 1-12 15-23 kg, 45 mg PO BID for 5 days Ages 1-12 23.1-40 kg, 60 mg PO BID for 5 days Ages 1-12 >40 kg, 75 mg PO BID for 5 days</p> <p>Baloxavir marboxil is weight based in patients \geq age 12: < 80 kg, 40 mg PO x 1 dose > 80 kg, 80 mg PO x 1 dose Baloxavir marboxil is not approved for use in children under the age of 12</p> <p>Treatment should be started within 48 hours of symptom onset in low-risk patients as there is no meaningful benefit after that time. In high-risk patients, treatment should be initiated even if past 48 hours from the onset of symptoms. Early and widespread use of antivirals may reduce hospitalization and severe disease in at-risk patients. Antiviral treatment is recommended, regardless of symptom duration, for any patient also diagnosed with concurrent community-acquired pneumonia.</p>
Summary	<p>Influenza is a seasonal illness seen commonly in urgent care centers. Testing is not required to make a diagnosis of influenza when there is activity within the community. A negative rapid influenza test does not rule out disease. Patients who fit a clinical diagnosis of</p>

	influenza should be started on anti-influenza medications if they are at high risk for complications even after 48 hours of symptom onset. Patients diagnosed with influenza who are not at high risk for complications may be started on anti-viral therapy within 48 hours of symptom onset. There is no benefit in these patients after 48 hours. Patients diagnosed with influenza should be isolated at home until they are fever-free for 24 hours off antipyretics.
References	https://doi.org/10.1093/cid/ciy866 https://doi.org/10.1164/rccm.201908-1581ST
Reviewers	Chris Chao, MD, Joseph Toscano, MD, Tracey Davidoff, MD, FCUCM
Attachments (flow charts, graphics, tables, etc.)	Table 1 (High-risk flu) Table 2 (Flu symptoms) Flowchart for diagnosis/management

Table 1: Health and age factors that are known to increase a person’s risk of getting serious complications from flu:

- Adults 65 years and older
- Children younger than 2 years old¹
- Asthma
- Neurologic and neurodevelopment conditions
- Blood disorders (such as sickle cell disease)
- Chronic lung disease (such as chronic obstructive pulmonary disease [COPD] and cystic fibrosis)
- Endocrine disorders (such as diabetes mellitus)
- Heart disease (such as congenital heart disease, congestive heart failure and coronary artery disease)
- Kidney diseases
- Liver disorders
- Metabolic disorders (such as inherited metabolic disorders and mitochondrial disorders)
- People who are obese with a body mass index [BMI] of 40 or higher

- People younger than 19 years old on long-term aspirin- or salicylate-containing medications.
- People with a weakened immune system due to disease (such as people with HIV or AIDS, or some cancers such as leukemia) or medications (such as those receiving chemotherapy or radiation treatment for cancer, or persons with chronic conditions requiring chronic corticosteroids or other drugs that suppress the immune system)
- People who have had a stroke

Other people at high risk from the flu:

- Pregnant women and women up to 2 weeks after the end of pregnancy
- People who live in nursing homes and other long-term care facilities
- People from certain racial and ethnic minority groups are at increased risk for hospitalization with flu, including non-Hispanic Black persons, Hispanic or Latino persons, and American Indian or Alaska Native persons
- ¹ Although all children younger than 5 years old are considered at high risk for serious flu complications, the highest risk is for those younger than 2 years old, with the highest hospitalization and death rates among infants younger than 6 months old.

From: <https://www.cdc.gov/flu/highrisk/index.htm>

Table 2: People who have flu often feel some or all of these symptoms:

- fever* or feeling feverish/chills
- cough
- sore throat
- runny or stuffy nose
- muscle or body aches
- headaches
- fatigue (tiredness)
- some people may have vomiting and diarrhea, though this is more common in children than adults.

*It's important to note that not everyone with flu will have a fever.

From: <https://www.cdc.gov/flu/about/keyfacts.htm#diagnosing>

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. Where is masking considered unnecessary for fully vaccinated individuals:
 - a. Restaurants on the inside
 - b. Were required by federal law
 - c. Where required by tribal law
 - d. Where ill patients are present
2. Select the correct statement:
 - a. Resistance is not a side effect of prolonged antibiotic use.
 - b. Antibiotic-inappropriate prescribing for respiratory diagnoses was lowest in urgent care centers in comparison to other ambulatory settings.
 - c. Clinicians should prescribe antibiotics for a minimum of 10 days for Community Acquired Pneumonia.
 - d. For non-purulent cellulitis, clinicians should prescribe a 5- to 6-day course for patients able to self-monitor and who have close follow-up with primary care
3. How did last years influenza season compare to previous
 - a. Very similar to the last three years
 - b. Much worse in morbidity and mortality from influenza
 - c. Very light compared to last 10 years
 - d. Influenza tracking was not performed due to the pandemic
4. Red flag vital signs are important because:
 - a. Insurance expects us to define them
 - b. Providers should be made aware of their presence immediately
 - c. Medicare defines them for their patient population
 - d. There is no such term in the sample policy

Answers from last month

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

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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