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URGENT CARING

COLLEGE OF URGENT CARE MEDICINE

OFFICIAL NEWSLETTER OF THE COLLEGE OF URGENT CARE MEDICINE

CUCM PRESIDENT - Jasmeet Bhogal, MD

Urgent care clinicians all over the country are working hard to provide the highest quality care to their patients and communities. As the needs of every patient differ, the goal that needs to be set for each patient can differ as well. Our vision, however, is something that has to be common.... it needs to be aligned. Antibiotic stewardship is an important aspect of what the current focus is within the College. Our vision is to see urgent care clinicians be the champions of antibiotic stewardship and lead this change nationally.

CDC estimates that in outpatient settings, 30 percent of all antibiotics prescribed in outpatient clinics are unnecessary. Even when antibiotics are needed, prescribers often favor drugs that may be less effective and carry more risk over more targeted first-line drugs recommended by national guidelines. Given that there are currently more than nine thousand urgent care clinics within the United States and more opening at a rapid pace, these statistics become relevant to us as a clinician community. We need to ask ourselves some questions: Are we communicating enough as a group of clinicians? Are we discussing this issue frequently enough amongst ourselves? How do we engage our peers to be the champions of antibiotic stewardship? How do we engage patients to be advocates for antibiotic stewardship? What information, data and/or education do urgent care clinicians need in order to develop strategies that will help better navigate the troubled waters of excess antibiotic use? Within our clinics and in our communities, are we doing enough to raise awareness regarding this important issue? And many more such questions.

As the College's Antibiotic Stewardship Committee continues to work on this issue, nothing would give us more pleasure than to see our members getting more involved and engaged in this discussion. Our doors are always open for our members to join in these discussions and be part of these committees. We are confident that vision aligns well with that of our members.

If you are interested in being part of the committees, please contact me at dr_jsbhogal@yahoo.com. I look forward to hearing from you.

EDITOR'S CORNER - Sean M McNeeley, MD

TO LEAD OR FOLLOW: THAT IS THE QUESTION

Year two of *Urgent Caring* is here. This year we plan to be bigger, better and full of news and information for clinicians who work in the on-demand space. As our president, Dr Bhogal, has explained, the College has ambitious goals to make life easier for us providers and our patients. There are many challenges for our specialty now and we expect more in the future. Others are making decisions about how we care for our patients and the future of this specialty. We have two choices: lead or follow. The College plans to lead.

Where do you stand? If you wish to lead, you can face these challenges alone or as part of CUCM. Individually you can make changes, but as a group we can do so much more. Join CUCM today. The more providers we represent, the greater our influence. Send in a case or an article for this newsletter. Join a committee. You may decide to run for a position on the board this fall. Every little bit counts.

Contact Dr. Sean McNeeley: smc@mcucm.org

NEW IN THE LITERATURE

Part 1: BBTI, New Blood Test for Concussion

Dr. Yehl is a member of the CUCM board of directors

On February 14, 2018, The US Food and Drug Administration approved marketing of the first blood test to evaluate the need of computed tomography (CT) in patients with mild traumatic brain injury by Banyan Biomarkers in San Diego. "Availability of a blood test for concussion will help health care professionals determine the need for a CT scan in patients suspected of having mTBI and help prevent unnecessary neuroimaging and associated radiation exposure to patients."[2] An FDA initiative was set to decrease exposure to unnecessary radiation and the BBTI fits into it nicely, passing in only 6 months. The Pentagon performed 2,000 blood tests leading to the approval of the BBTI. [3] The BBTI measures two proteins that are released into the bloodstream after a mild TBI. The two proteins are ubiquitin C-terminal hydrolase (UCH-L1) and glial fibrillary acidic protein (GFAP). GFAP is a protein expressed by astrocytes and UCH-L1 is expressed by neurons. When a head injury occurs, these two proteins are leaked from the cells and enter the bloodstream. Both are detectable within one hour after mTBI. UCH-L1 rises rapidly, peaking at 8 hours, while GFAP rises slowly, peaking at 20 hours and declining over the following 72 hours. Currently, the standard of care after head trauma is for the clinician to perform a neurological evaluation and CT scan, if indicated. The prosed utility of the test is to avoid unnecessary CT scans. The BBTI proteins are detectable by a point of care (POC) test approximately 12 hours after a head trauma. The test is approved for use in adults only currently. The test leaves many questions, such as what will the patient demand be? Will it change our management after normal neurological exams? What will be the price and utility be for the standard urgent care center? Will this testing be available to non-clinicians in sports or battlefields? We will look at these questions in Part 2 of the series BBTI Testing.

[1]US FDA. FDA authorizes marketing of first blood test to aid in the evaluation of concussion in adults. FDA News Release. February 14, 2018. Retrieved from https://www.fda.gov/newsevents/newsroom/pressannouncements/ucm596531.htm

[2]Banyon Biomarkers, 2018. Developing the First Objective Blood Test for Traumatic Brain Injury. Retrieved from https://banyanbio.com/

Kaplan,S & Belson,K. (2018).

[3]"Concussions' Can Be Detected With New Blood Test Approved By FDA". New York Times, February 14, 2018. Retrieved from https://www.nytimes.com/2018/02/14/health/concussion-fda-bloodtest.html

CASES FROM OUR MEMBERS

A worrisome rash

Chrysa Charno, MBA, PA-C is a member of the CUCM board

HPI: This is a 34 yo healthy female with no past medical history who presents complaining of a rash on the bilateral upper and lower extremities x 2 weeks. She states that red spots first started on her bilateral lower legs 2 weeks ago, after no known new exposures or illness. She was seen at urgent care and it was believed that she had spider bites as there was a central papule in each lesion. She was started on Bactrim DS BID. The rash progressed up the lower extremities and then started to appear on the upper extremities yesterday. Patient notes that the rash on her arms appears more like hives and she began to experience joint pain in her left ankle to the point where she has difficulty walking. She reports the lesions start with a burning sensation in the skin and then the color appears a day later. No other joint swelling. Rash spares the trunk. No mouth lesions. She also states she has a few random areas of bruising on her thighs.

PE: Afebrile, vitals stable. Examination of the rash on the bilateral forearms reveals urticarial

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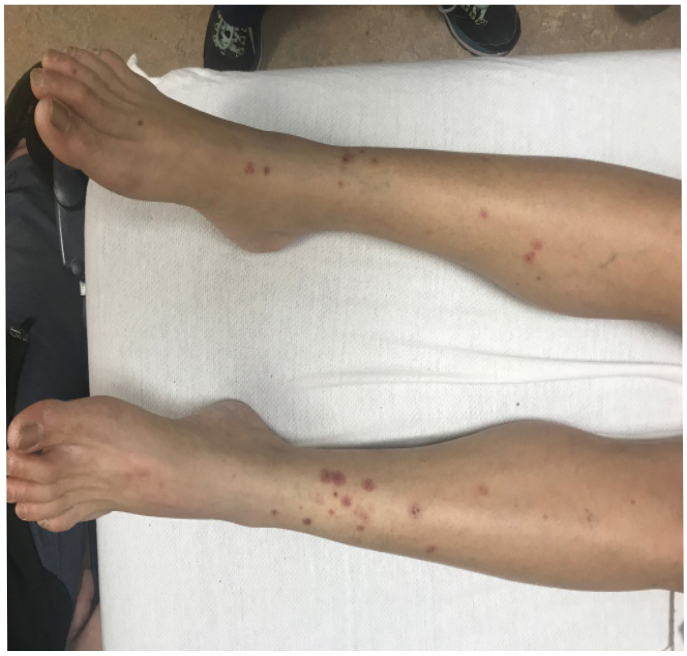

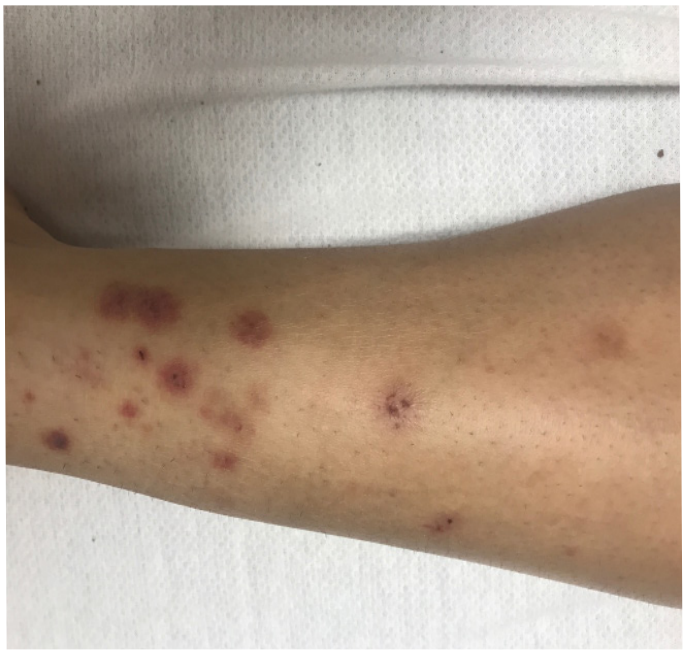

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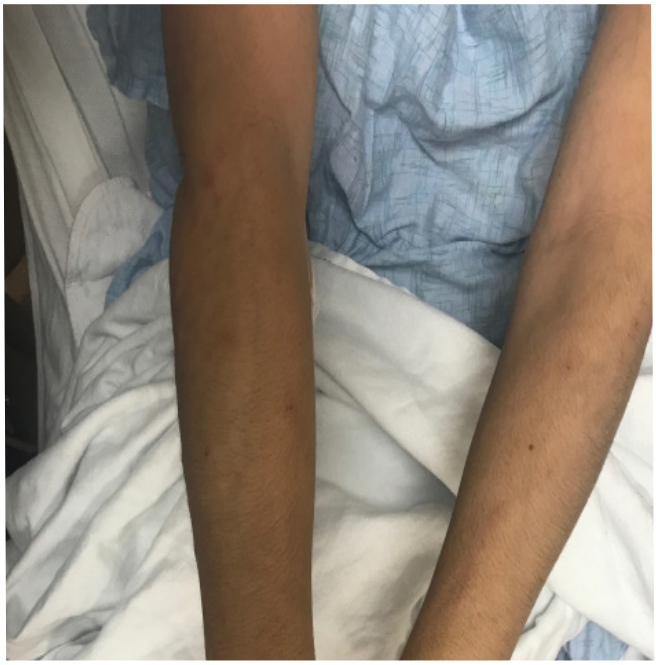
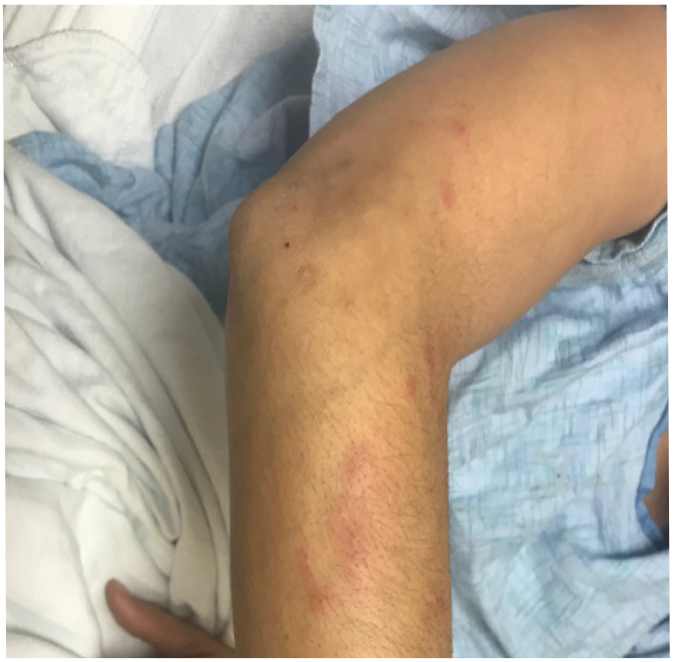
wheals in no particular pattern. The rash stops at the elbows. Examination of the bilateral lower extremities reveals non-blanching petechial macules, no vesicles. No involvement of the nails. The left ankle is very tender with ROM but no asymmetrical swelling noted. Diagnosis: Suspect urticarial vasculitis, no biopsy was performed at time of visit. Patient was discharged with a 14 day prednisone taper and NSAIDs. Follow up with Dermatology.

Discussion: Urticarial vasculitis is an urticarial eruption that is often painful or has a burning sensation prior to the eruption of lesions. Lesions are red patches or plaques and petechiae may appear. They usually last for more than 24 hours and then as lesions resolve an area of ecchymosis is present. The cause of the lesions is usually unknown but can be associated with SLE, Sjogren syndrome, leukemia, viral disease such as Hepatitis B/C and can also be drug-induced from ACE inhibitors, PCN, sulfonamides, fluoxetine and thiazides. The majority are idiopathic.





ANOTHER CASE FROM OUR MEMBERS

Bell's Palsy - Not always benign

Chris Chao, MD is a new member of the CUCM board of directors

A 45 year old male presented to urgent care late afternoon with a chief complaint of "left sided facial drooping." He states that he was at baseline health until he woke up this morning and felt "tingling" on the left side of his face. When he looked in the mirror, he noticed that his left side of the face was drooping. He did not seek medical attention immediately because he had a previous episode of Bell's palsy on the right side of his face, and he knew that "there was nothing that could be done and symptoms just went away." He presented to urgent care upon the insistence of his spouse, who was concerned because he "just didn't look well."
Patient's history is significant for hypertension and diabetes, both controlled with medications. He reports that 5 days ago he went to his primary care provider for left sided ear pain. He was diagnosed with acute otitis externa and otitis media and prescribed antibiotic ear drops and oral Amoxicillin.
On examination today, patient appears uncomfortable but non-toxic. Vital signs: Temperature 101.4 F (oral), HR 104, BP 150/90, RR 18. Patient noted to have left sided facial paralysis that involves the forehead. Further examination reveals exquisite tenderness behind the left ear lobe, and his auditory canal is swollen and painful. Patient is unable to open his mouth without discomfort. Patient reports pain in the ear is 10/10.
Patient was transferred to the Emergency Department due to concern about malignant otitis externa versus mastoiditis. CT scan confirmed that patient had mastoiditis. ENT was consulted, and he was taken to the OR for surgical exploration and debridement. He was subsequently admitted as an inpatient for IV antibiotics and eventually discharged home. He was lost to follow-up after hospital discharge.

Bell's palsy
Patient presented to urgent care with the classic signs of Bell's palsy. He had acute onset of left sided upper and lower facial paralysis resulting in facial droop and impaired eyelid closure. Bell's palsy is differentiated from a central process, because in Bell's palsy, the forehead and face are involved, whereas in a central process lesion (i.e. stroke), the forehead is spared. Though the exact cause of idiopathic Bell's palsy is unknown, providers will often treat with corticosteroids in the acute phase to reduce inflammation and decrease time to recovery. HSV and other viral pathogens have been implicated as a possible cause, though routine treatment with acyclovir or valacyclovir has not been shown to improve outcomes.

Mastoiditis
Mastoiditis is infection of the mastoid bone, and is a serious complication of ear infections, typically otitis media. Prior to antibiotics, mastoiditis was a frequent complication of acute otitis media. In this case, mastoiditis had progressed to involve the facial nerve, which caused the patient's Bell's palsy. This is a medical emergency and prompt referral to the Emergency Department or ENT specialist is critical. Risk factors for mastoiditis in adults include immunocompromised state and diabetes.

In closing, Bell's palsy is a common diagnosis in urgent care. The majority of patients with Bell's palsy will recover without medical intervention. However, be aware that more serious conditions such as mastoiditis may be lurking as a cause.

ANOTHER CASE FROM OUR MEMBERS

Lyme disease strikes again

Dr Yehl is a memer of the CUCM board of directors.
A 22 year old male presents to urgent care with complaints of a lump on his back. He removed 2 other ticks this month and is suspicious it is a tick. He was landscaping his yard in Scarsdale, New York 2 days ago and working in the brush. He denies any complaints, and vital signs are normal. On exam, an engorged *Ioxodes scapularis* tick is found on his left upper back. It was removed without difficulty. The patient wants to know if he should take any medicine to prevent Lyme disease.
When our patients live in wooded areas and are often removing ticks, it is difficult to decide when to use prophylactic treatment. The Infectious Disease Society of America (IDSA) has published clear guidelines for patients who live in endemic areas with tick exposures. Routine use of antibiotics or serologic testing is not recommended by IDSA. The IDSA recommends ALL criteria be met in order to be prescribed doxycycline single dose prophylaxis. Dosing for doxycycline for adults is 200 mg once, or for children 8 years or greater 4 mg/ kg up to 200 mg once. No alternative medications are recommended for pregnant patients, children less than 8 years old or doxycycline-allergic patients currently.

1. Doxycycline is NOT contraindicated by the patient's medical history.
2. The tick was identified as an adult or nymph *Ioxodes scapularis* tick.
3. The tick was attached equal to or greater than 36 hours decided upon by state of engorgement or reported exposure time.
4. Prophylaxis is within 72 hours of tick removal.
5. Lyme disease is common in the place of residence of the patient or area of exposure.

States with the highest rates of Lyme disease are Connecticut, Delaware, Maine, Maryland, Minnesota, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, Virginia, Vermont and Wisconsin.
The infected tick needs to be attached for approximately 36 hours to transmit the *B. Burgdorferi* spirochete. If the patient has symptoms of an infection such as an erythema migrans rash, fever or joint pain, the treatment is extended. This single-dose regimen is for the patient without symptoms, whom meets all the criteria stated. No alternative medications are recommended for pregnant patients, children less than 8 years old or doxycycline-allergic patients currently. It is unknown if doxycycline prophylaxis will prevent other tick-borne diseases and it is not recommended for them.

1. CDC (2012). Tickborne Diseases of the United States. Accessed on September 26, 2017. https://www.cdc.gov/ticks/tickbornediseases/tick-bites-prevention.html
2. Clinical Infectious Diseases, Volume 43, Issue 9, 1 November 2006, Pages 1089–1134, https://doi.org/10.1086/508667. Accessed on September 26, 2017. https://academic.oup.com/cid/article/43/9/1089/422463/The-Clinical-Assessment-Treatment-and-Prevention

Increase Urgent Care Medicine's Representation: Update Your Practice Specialty with the AMA Today

The American Medical Association keeps records in their "Masterfile" of all physicians in the United States, even if they are not AMA members. Did you know that urgent care medicine is one of the self-designated specialties? There is strength in numbers, so if you are not currently self-designated as practicing urgent care medicine as your primary or secondary specialty (you are allowed to list up to two specialties you practice), please call the AMA now to correct this. Call 1-800-621-8335, select option "2" and then option "5", to speak to an AMA representative and update your status.

ABOUT US

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 of America (UCAOA) to provide a physician voice for the specialty. CUCM and UCAOA 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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