Welcome!

Top Tips from the 2023 UCA Convention

Speaker: Joseph Toscano MD, FCUCM
Moderator:
Host:

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URGENT CARE ASSOCIATION®

Corticosteroid Stewardship

Benefit > Risk for parenteral corticosteroids

- Adrenocortical insufficiency
- Some allergic reactions, anaphylaxis
- RAD/COPD exacerbations
- Toxic pulmonary edema
- Nephrotic syndrome, rheumatoid diseases
- Cerebral edema
- Organ transplant
- Preterm delivery
- Bells palsy
- Gout

Corticosteroid Stewardship

Risks

- Fractures, AVN, thrombotic disease, sepsis, GI bleeding, CHF
- Inhaled steroids – thrush, glaucoma, cataracts
- The risk is cumulative – as little as 500 mg of lifetime prednisone/ prednisolone
- Insurance database study, 5-90 days after use – sepsis 5x, VTE 3x, fractures 2x
- CS are the third most common medication involved in malpractice claims
- Consider documenting specific consent in situations where the Rx is appropriate

Corticosteroid Stewardship

Do not use for

- Acute bronchitis/sinusitis
- RTIs in general
- Allergic rhinitis
- Carpal tunnel syndrome

Insufficient evidence for

- Acute pharyngitis
- Zoster
- Radiculopathy

Diagnosing Urinary Tract Infection

- Dysuria + LH 1.5
- Frequency + LH 1.8
- Back pain + LH 1.6
- Hematuria + LH 2.0
- Self-diagnosis + LH 4.0
- No discharge + LH 3.1
- No irritation + LH 2.7

- Cystitis, pyelonephritis
- Vaginitis, urethritis
- Kidney stone
- Functional bladder issue
- Interstitial cystitis

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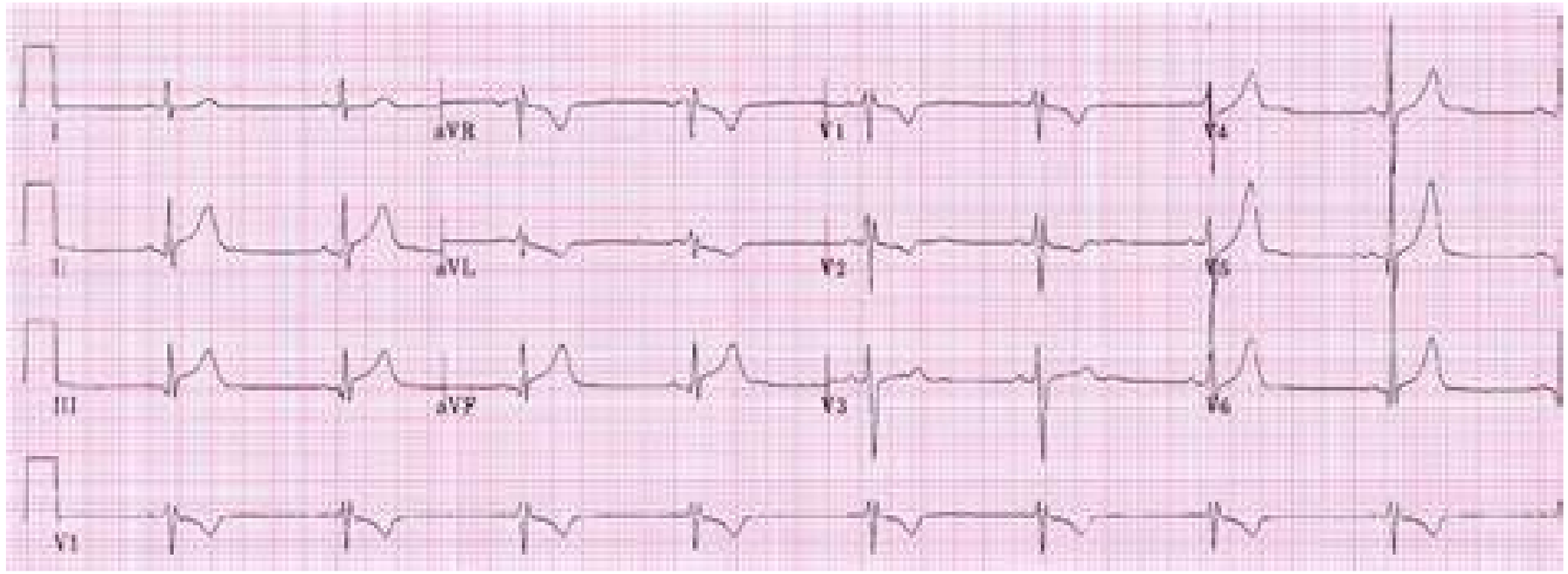
EKG Interpretation – “Obstructive MI Patterns”

Hyperacute T waves



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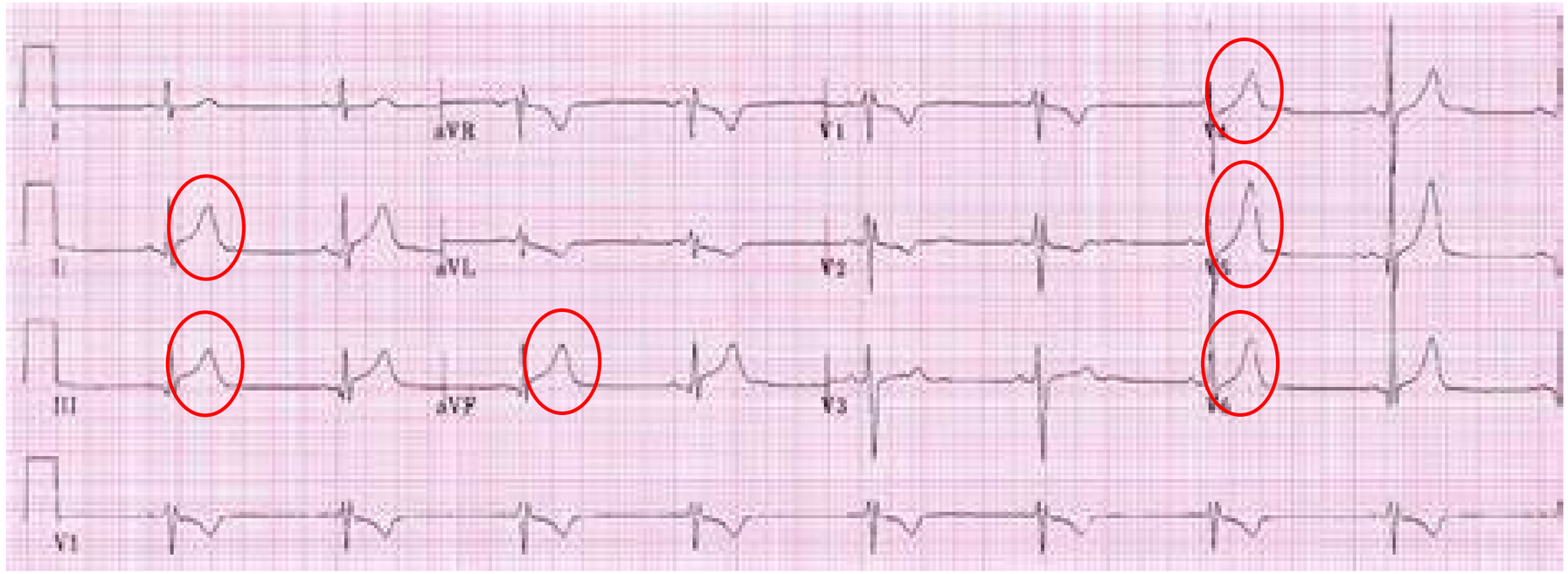

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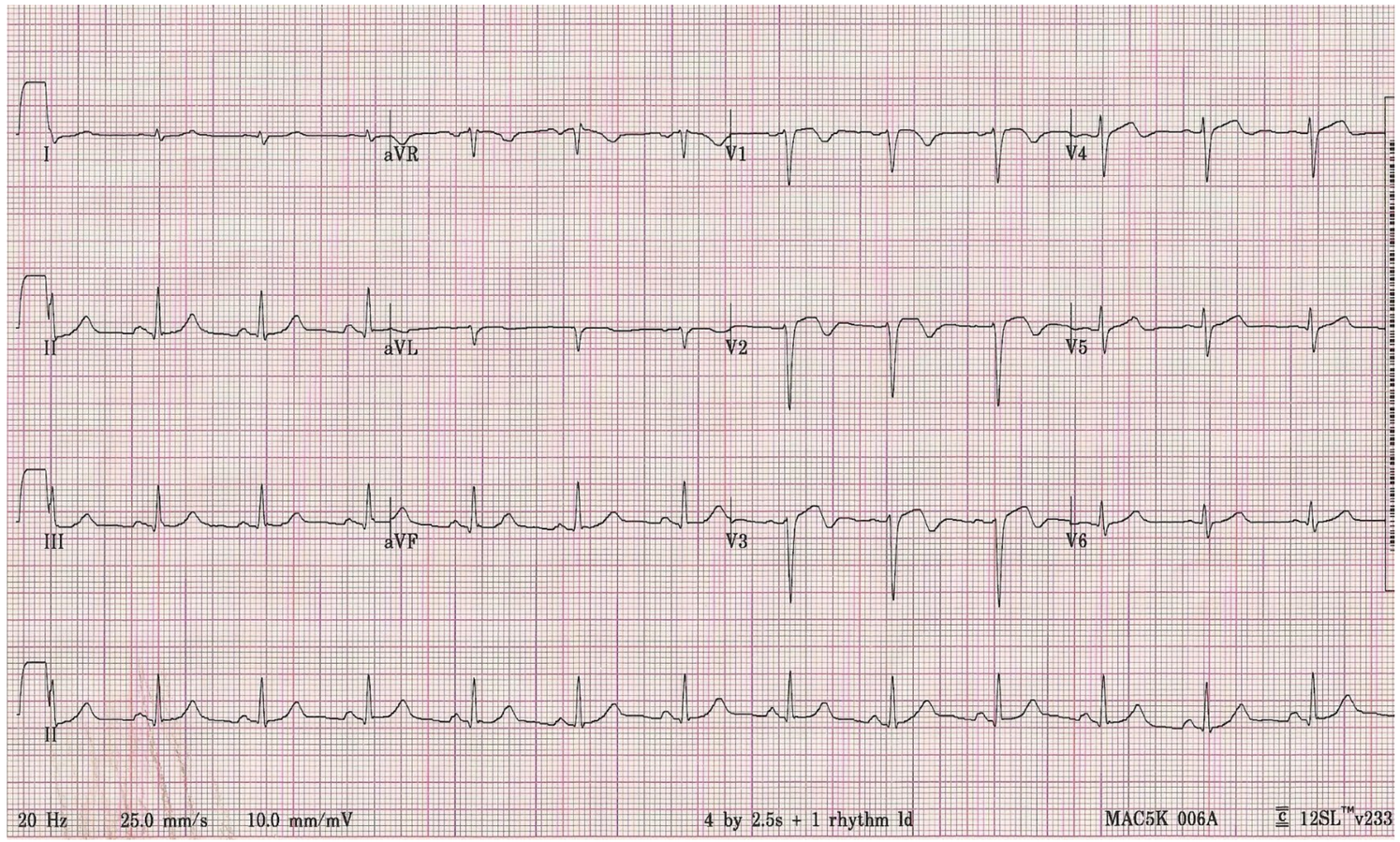
Wellens Syndrome

- Precordial changes
- Biphasic ST/T



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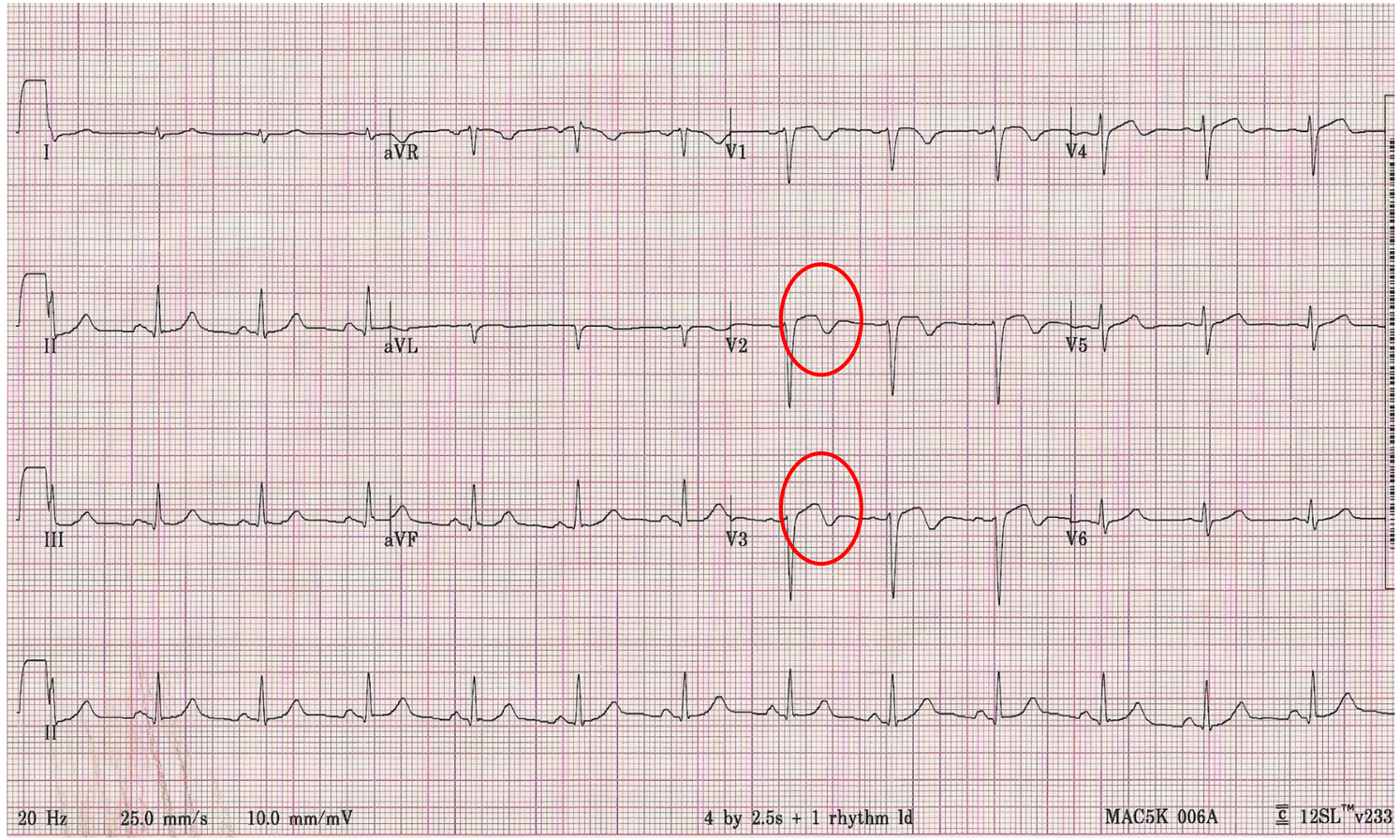

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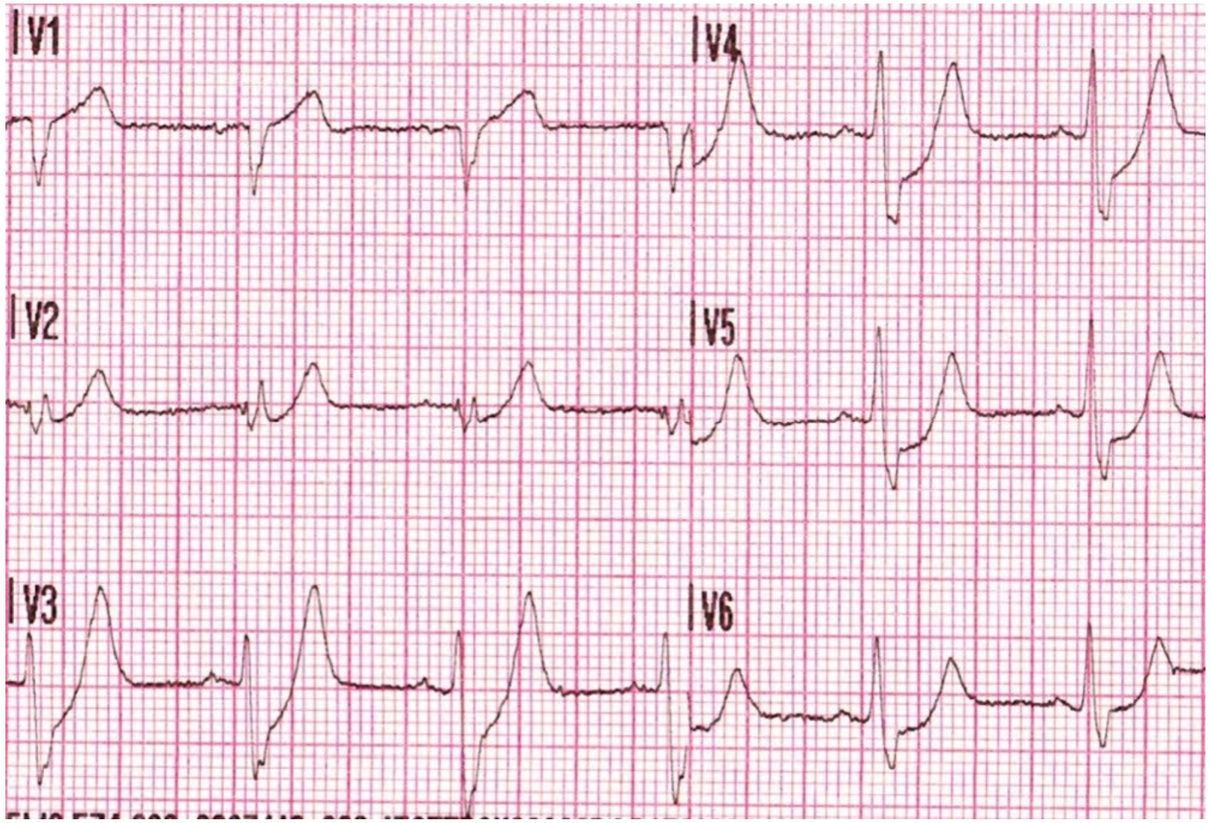
EKG Interpretation – “Obstructive MI Patterns”

deWinter T waves

- Precordial changes
- > 1 mm ST depression
- Tall T wave
- +/- STE in aVR



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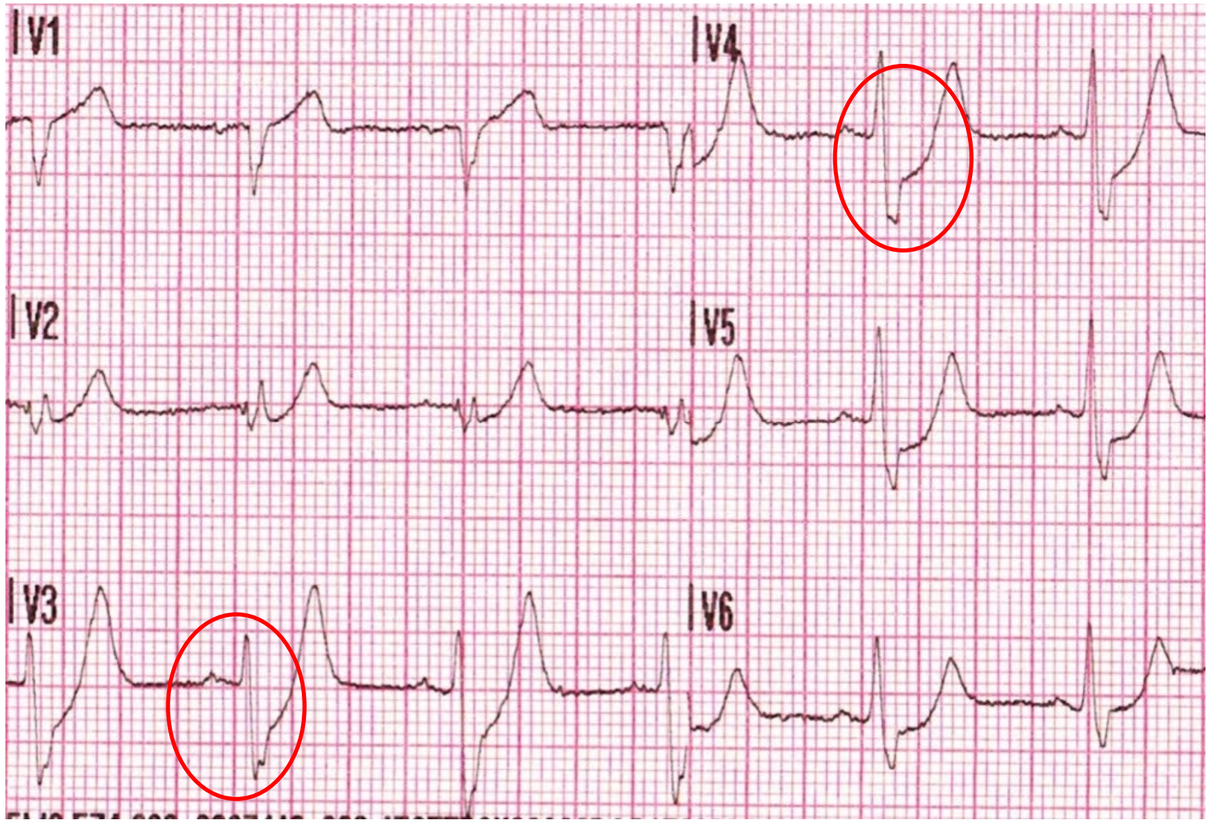

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EKG Interpretation – “Obstructive MI Patterns”

Others

- ST elevation in 2 inferior leads with ST depression in aVL
- New RBBB and LAHB
- > 1 mm ST elevation in aVR
- Isolated posterior MI – ST depressions in V1-V4 but not V5-6 and not needed in V7-9

Medicolegal Pitfalls

- For DC instructions, no difference between written vs computerized
- There DO need to be: time- and action-specific, verbal and on paper
- Use fluoroquinolones only when there is a clear advantage or no alternative and document why as well as patient understanding
- Know the boundaries of being recorded (audio, video) by patients
- Be careful what you post on social media

Bulletproof Charting

- Check the vitals
- Address the chief complaint
- Think “What could go wrong?”
- Beware the template
- Use algorithms appropriately
- Re-examine patients when needed

Treating Sexually Transmitted Infections

2021 update

- Ceftriaxone 500 mg is the new dose (1 g if body weight ≥ 150 kg)
- Doxycycline is preferred to azithromycin for chlamydial infections
- For PID – ceftriaxone IM, doxy and metronidazole x 14 day
- The alcohol ingestion advisement is no longer needed for metronidazole
- *Mycoplasma genitalium* incidence is on the rise → AMR testing
- Screen for Hep C and HIV in anyone seeking treatment for STI
- HSV is still a clinical diagnosis
- Be familiar with your state's expedited partner treatment status
- https://www.cdc.gov/std/treatment-guidelines/default.htm

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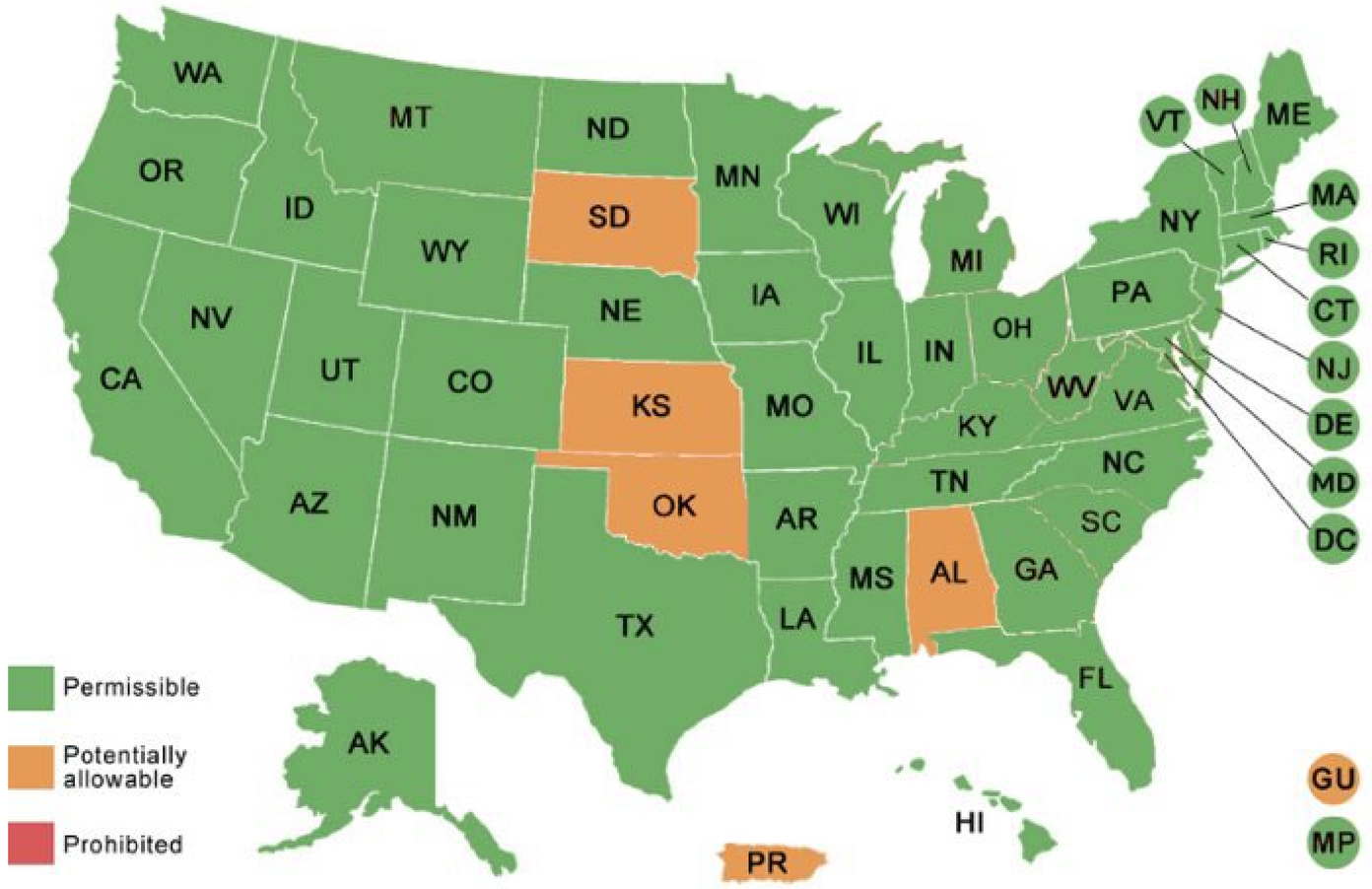
Treating Sexually Transmitted Infections



As of:
April 2021

https://www.cdc.gov/std/ept/legal/default.htm

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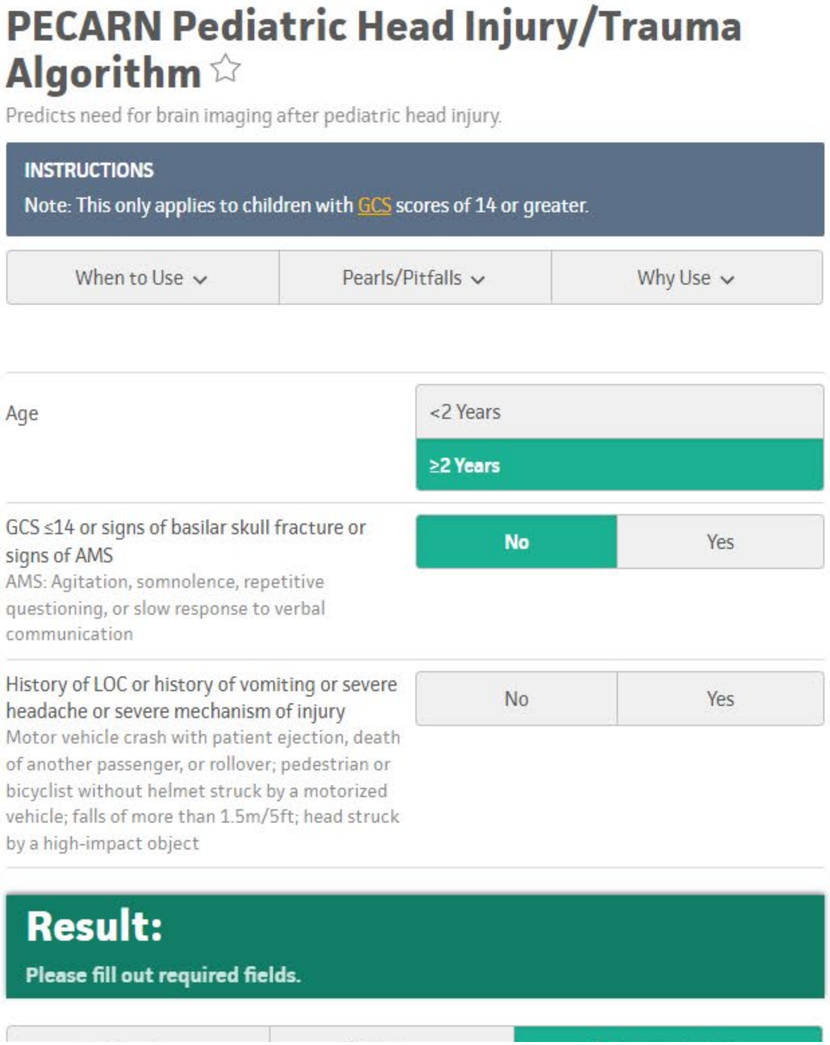
Community-acquired Pneumonia

- 2019 IDSA/ATS Guideline
- Cover atypical and typical organisms
- Consider drug-resistant *S. pneumoniae* (DRSP) factors
  - age < 2 or > 65
  - comorbidities, immune-suppression
  - *B*-lactam exposure within prior 3 months
  - children in day-care and exposure to them
- For exposure to **any** antimicrobials within the prior 3 months
  - choose a medication from a different class

Community-acquired Pneumonia

- 1st line: Amoxicillin 1g TID or Doxy 100 BID
- High-risk: Amoxicillin/clavulanate OR Cefpodoxime or Cefuroxime + Macrolide
- High-risk: Levofloxacin, Moxifloxacin, Gemifloxacin
- Treat for 5 days and reassess
- Risk-stratify for disposition (CURB-65, PORT/PSI)
  - Confusion, BUN > 19, RR $\geq$ 30, BP < 90 sys $\leq$ 60 dias, age $\geq$ 65

Using Clinical Calculators



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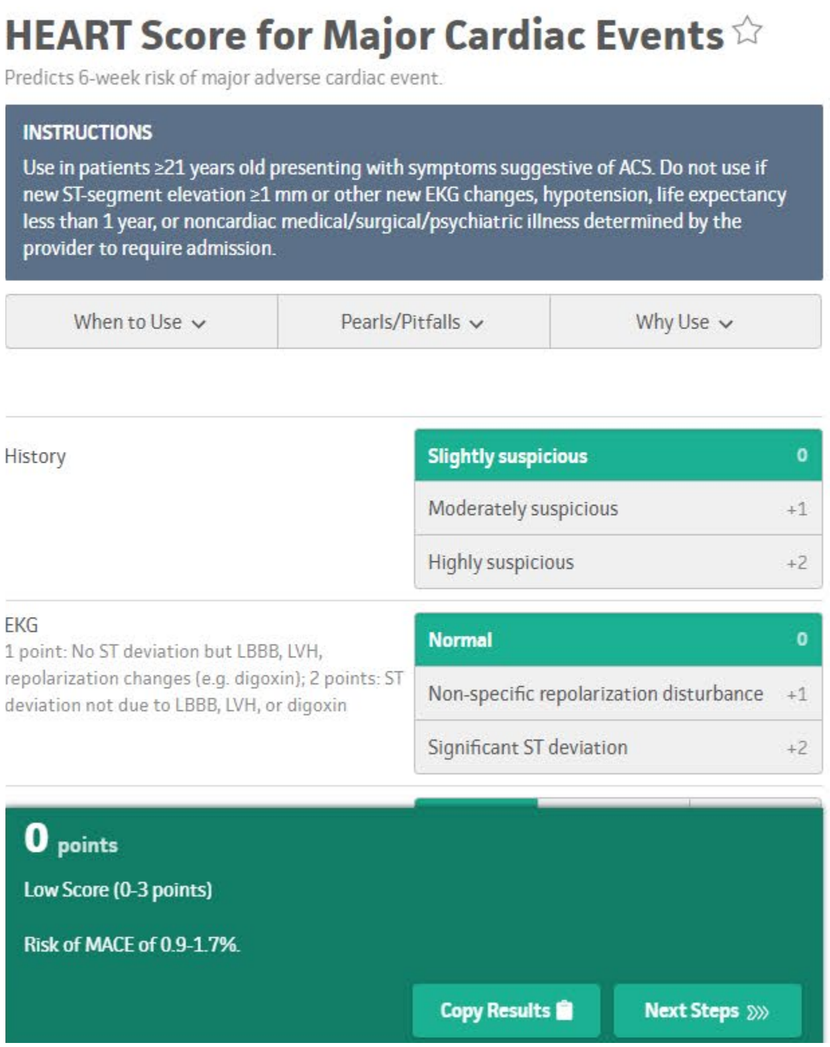

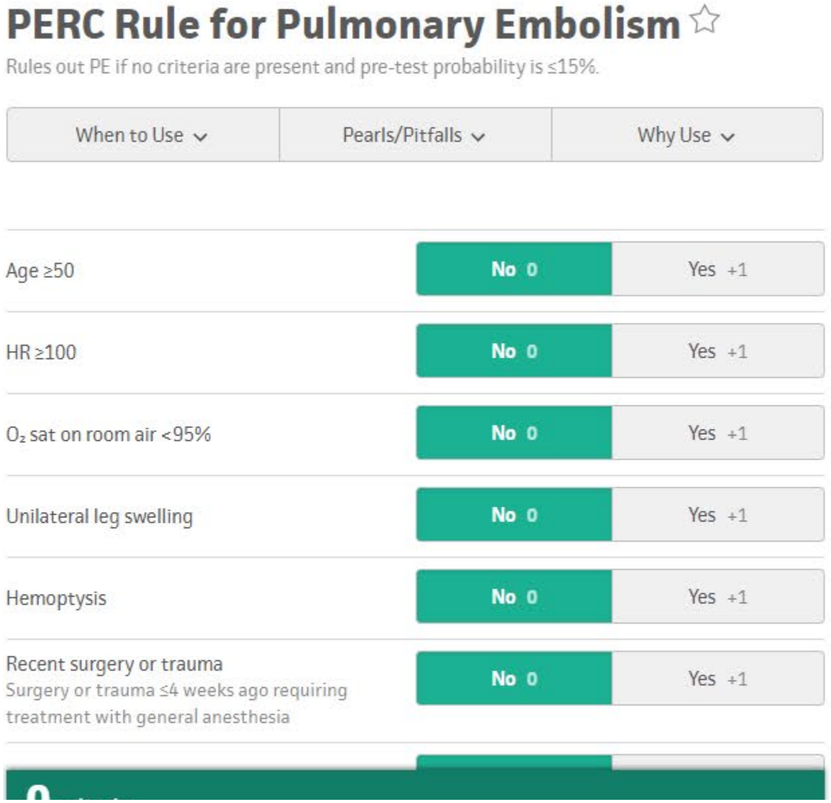

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Paper Chase

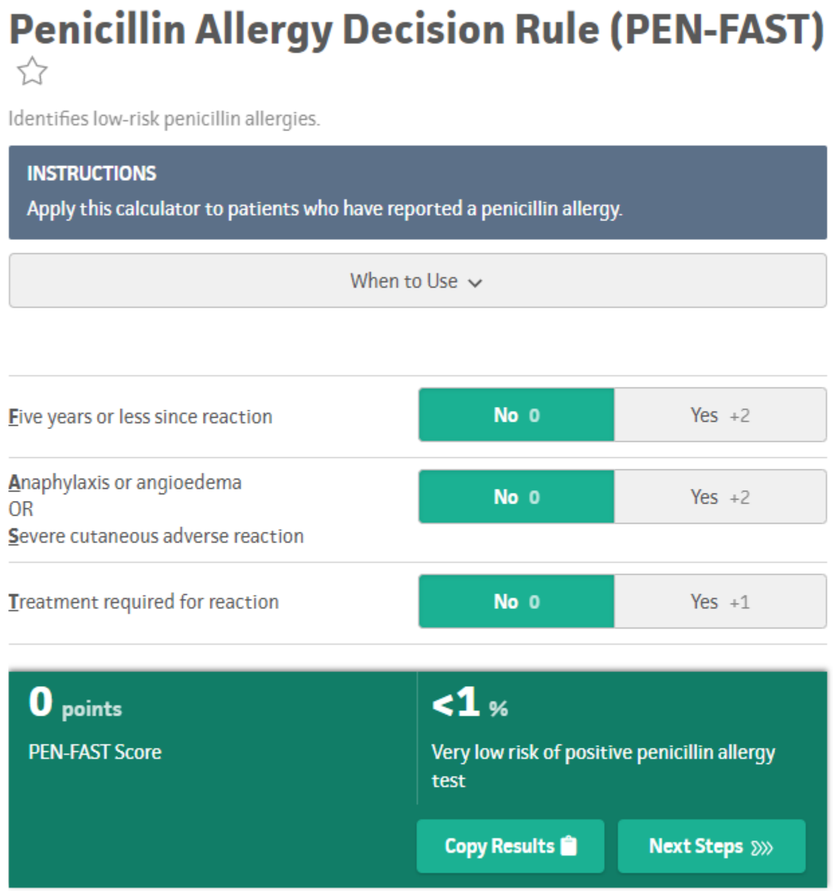
- *JAMA Netw Open*. 2022;5(10):e2234459 – Topical ophthalmic antibiotics were associated with a significantly shorter duration of conjunctival symptoms in children with acute infective conjunctivitis.
- *CJEM*. 2023 Jan;25(1):22-30 – Pilot RCT, 1000 mg QID vs 500 mg QID, both x 7 days, resulted in fewer (3.2% vs 14.2%) treatment failures but higher minor adverse events.
- *Acad Emerg Med.* 2023 May:30(5):541-551 – Canalith repositioning maneuvers are superior to vestibular suppressants for most outcomes in BPPV.

Paper Chase

- *CJEM*. 2022 Dec;24(8):809-819 – Intraarticular lidocaine showed similar reduction success for anterior shoulder dislocations as IV sedation, with fewer adverse reactions and shorter LOS and no difference in pain scores.
- *Clin Infect Dis.* 2023 Jan 13;76(2):185-191 – 25 mg Zn BID x 15 d resulted in lower ICU admit rates, shorter hospital LOS and decreased sxs for Covid 19
- *J Asthma Allergy.* 2021 Jan 18;14:31-46 – Incidence of true beta-lactam allergic cross-reactivity is low.

Paper Chase – Penicillin-allergic cross-reactivity

- *JAMA Int Med.* 2020;180(5):745-752 – Validated the PEN-FAST Decision Rule
- 0 points < 1% penicillin skin test allergy (very low risk)
- 1-2 points 5% penicillin skin test allergy (low risk)
- 3 points 20% penicillin skin test allergy (moderate risk)
- 4-5 points 50% penicillin skin test allergy (high-risk)
- Educate patients; trial of cephalosporin (or even PCN) is OK for very low risk patients; refer those with moderate or high risk for testing
- https://www.mdcalc.com/calc/10422/penicillin-allergy-decision-rule-pen-fast



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Important Papers from the Literature

- *Lancet*. 2022 Jul 2;400(10345):39-47 – Ace wrap equivalent to rigid support in the treatment of torus fractures
- *Acad Emerg Med*. 2022 Aug;29(8):1027-1032 – Nontoxic patients with prepatellar bursitis that seemed infectious did OK with empiric antibiotics without aspiration (retrospective)
- *JAMA Netw Open.* 2022 Oct 3;5(10):e2234588 – POC testing (blood CRP and myxovirus resistance protein A) performed similar to lab testing, a more complicated algorithm and clinical followup in distinguishing between acute viral and bacterial RTIs.

Important Papers from the Literature

- *European Journal of Emergency Medicine.* 2021, 28:432–439 – Modified Valsalva maneuver > 4 times more likely to convert SVT than usual VM
  - Patient sits up straight and performs a forced expiration for about 15 sec
  - Then patient is brought into a supine position with the legs raised (45°) for another 15 sec
- *Pediatric Emergency Care.* 2022 Oct 1;38(10):477-480 – At 2 month followup, there was no cosmetic difference in pediatric patients with facial wounds randomized to repair with tissue adhesive alone vs adhesive over skin strips. And using strips took longer, but……

Non-opioid Pain Management

- Start simple – hot/cold therapy, movement
- Combination of ibuprofen 400 mg q3-4 hour and APAP 500 mg q3-4 hours almost equivalent to opioid analgesia
- Good data for topical diclofenac, lidocaine, capsaicin
- Consider dental blocks
- Consider occipital nerve block for migraine headache

A Non-dizzying Approach to Dizziness

- Evaluate for central findings early
  - diplopia, dysphagia, ataxia
  - dysmetria (FNF, HKS), gait and truncal ataxia
- Use Dix Halpike maneuver to diagnose BPPV
- To confirm vestibulopathy, use the HINTS exam
  - Nystagmus is usually only horizonal, and is never bidirectional or vertical
  - Test of skew – no eye movement with uncovering eye in fixed gaze
  - Catch-up saccades occur with head impulse testing

A Non-dizzying Approach to Dizziness

	Peripheral	Central
Nystagmus	horizontal, unidirectional	vertical, bidirectional
Test of skew	no eye movement	vertical eye movement
Head impulse	catch-up saccades	no saccades

Cellulitis

- Over-diagnosed and over-treated
- One study: 84% did not need to be admitted, 93% received unnecessary antibiotics

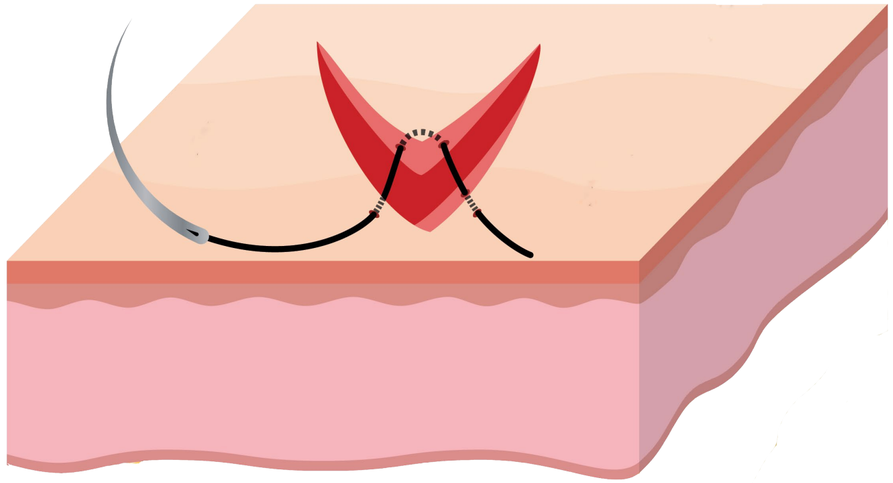
ALT-70 Prediction rule:

- Asymmetric – 3 pts
- Age ≥ 70 – 2 pts
- WBCs ≥ 10k – 1 pt
- HR ≥ 90 – 1 pt
- Score 0-2 ~82% pseudo-cellulitis
- Score 5 82% cellulitis

https://www.mdcalc.com/calc/3998/alt-70-score-cellulitis

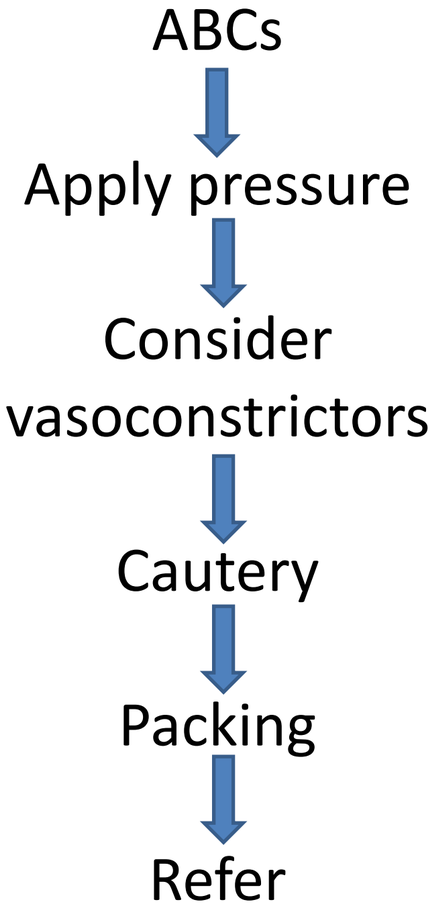
Procedure Pearls

- Try dermabond for nailbed injuries
- Use the “corner stitch” to close the apex of a V-shaped wound
- Use scapular rotation with shoulder reductions
- Consider Los Davos, FARES, or “chair reductions
- For oral mucosal bleeding, try lido with epi injection or 4-5% TXA swish (2 mins) and spit



Handling the Patient with Epistaxis

- ABCs first
- Stepwise approach – benefit *vs.* harm
- Hold pressure (correctly) – 5 mins or longer
- Determine whether this is going to be more difficult than “usual”
  - tumor or vascular malformation
  - recent trauma or surgery
  - anticoagulation or other bleeding disorder
- Equipment and meds



Wound Care – Diabetic foot ulcers

- > 2 cm diameter: + LR 7 - LR 0.5
- Probe to bone: + LR 6.5 - LR 0.4
- ESR > 70 mm/hr: + LR 11.3 - LR 0.3
- Changes on xray: + LR 2.3 - LR 0.6
- MRI: + LR 3.8 - LR 0.14
- Positive xray and positive probe to bone: + LR 12
- Negative xray and negative probe to bone: - LR 0.02