Challenging Times

We live in unprecedented times. COVID-19 has taken over the world, literally. What is happening around us is surreal. It is probably safe to say that none of us have had such an experience in our lifetimes. I hope that none of us have such an experience in the times to come.

Healthcare providers have been taxed with an enormous task during this crisis. While taking care of our patients is our job, we have had to deal with issues far beyond the norm. In addition to dealing with a new illness, a national shortage of PPE has further compounded the problem. Add to that the drastically low urgent care patient volumes that we all started experiencing a few weeks back. Many of our colleagues have had to deal with the issue of making tough decisions about maintaining their operations, and in some cases closing down some or a majority of their sites in order to stay afloat. Maintaining adequate staff while also protecting them from the disease itself is a complex task.

The College and the Urgent Care Association have been working to support our members. The COVID-19 Taskforce has been created with the goal of monitoring the current situation and also to develop and provide resources pertaining to COVID-19 for our members. The COVID-19 Taskforce has been an active group which is meeting every week. The group is constantly seeking feedback from the urgent care community and developing action plans in order to help our members.

a. COVID-19 Webpage: A COVID-19 resource page has been developed. Please visit this page to get the latest information pertaining to COVID-19. Link: https://www.ucaoa.org/Resources/Coronavirus-Resources.
b. Joint Statement with ACEP: CUCM has collaborated with ACEP to develop and release “Risk Stratification Guide for Severity Assessment and Triage of Suspected or Confirmed COVID-19 Patients (Adults) in Urgent Care”. This is available on the Webpage mentioned above. We are working with other organizations to develop similar clinical resources.
c. COVID Listserv: The COVID Listserv has been very active since its inception. There is some great information that is shared on this platform on a daily basis. If you are not already part of this Listserv, we would highly recommend that you join so that you can benefit from the information that everyone is sharing.

We at the College are extremely appreciative of the great work that you all are doing in this current situation. Every effort that you put in is a testament to the incredible grit that each of you carry. Thank you for all you do.

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A Light at the End of the Tunnel

As Dr. Bhogal noted we are facing challenging times. The situation is unprecedented in most of our lives, but this is not the first pandemic and we are not the first generation to deal with difficult times. After each of these events things did return to normal. Not to belittle the seriousness of the situation, but to assure ourselves that one day, hopefully soon, this will be over. We need to hold on to that. There is a light at the end of this long tunnel and thankfully it is not an oncoming train. So, tie a knot at the end of the rope and hang on. Together we got this.

Thank you for all you do. Our patients appreciate it.
Pediatric Practice Pearls -- “Coronavirus COVID-19 and Children – What is the Latest Information?”

Thomas W. Tryon, MD, MBA, FAAP, FCUCM; UCA Pediatric Section Chair

In my more than thirty years of healthcare practice, to say this has been and continues to be the most challenging time in my professional life would be an understatement. Daily, as the number of cases and deaths from COVID-19 infection and death rates rise, we realize the monumental battle we are facing and the incredible toll it is taking on healthcare providers, parents, grandparents and our nation. All our children are being affected in one way or another, even if it is simply by being out of school and homebound while we face this pandemic or from being ill from contracting the virus infection.

To this point for infants and children the news about disease severity appears to still be good. Coronavirus seems to be an infection that impacts adults much more than children. In addition, information from China and Italy on children who were infected with the virus seems to indicate that they had a rather mild infection that mimicked the common cold with a runny nose, sore throat, cough and fever. For this age group the risk of severe illness, hospitalizations and death appears to be very low. What is not known at this point is the role that children may have in spreading the disease, especially if they have very mild symptoms yet are contagious. There is much to be learned about COVID-19.

Based on a very recent article “COVID-19 and Children” published in the prestigious medical journal The Lancet on March 27th:

“Severe COVID-19 in children is rare. To date, the largest review of children with COVID-19 included 2,143 children in China. Only 112 (5.6%) of 2,143 children had severe disease (defined as hypoxia) and 13 (0.6%) children developed respiratory or multiorgan failure or acute respiratory distress syndrome (ARDS). At the time of writing, there have been two reported deaths in children testing positive for COVID-19 in China, and no deaths in Italy.” (https://www.thelancet.com/journals/lanres/article/PIIS2213-2600(20)30152-1/fulltext)

The news from the Centers for Disease Control concerning children is equally encouraging to date. From their website on April 6th:

“Relatively few cases of COVID-19 caused by SARS-CoV-2 infection have been reported in children compared with the total number of cases in the general population. As of Feb. 20, 2020, 2.4% of the 75,465 cases (confirmed and suspected) in China had occurred among persons younger than 19 years old. An analysis from one large city in southern China suggests that, among all cases, the proportion of children younger than 15 years old may have increased from 2% to 13% from early to later in the outbreak.”

While the Urgent Care Association continues to provide daily information concerning COVID-19 and patients from all age ranges and risk factors, as well as providing Listservs to tie frontline providers together, be aware that for pediatric-specific information, the American Academy of Pediatrics website (www.aap.org) has a COVID-19 link for healthcare providers that provides resources you may find helpful in your pediatric practice. One of those resources on HealthyChildren.org provides both practical and scientific guidance for parents. (https://www.healthychildren.org/English/health-issues/conditions/chest-lungs/Pages/2019-Novel-Coronavirus.aspx)

One such guidance is “Information for Families” that provides articles on:
• Working and Learning from Home During the COVID-19 Outbreak
• Social Distancing: Why Keeping Your Distance Helps Keep Others Safe
• Tips for Coping with a New Baby During COVID-19
• Positive Parenting & COVID-19: 10 Tips to Help Keep the Calm at Home

I trust this information and these resources will be of value to you, as you battle this pandemic working on the front lines. I have such great respect for your professionalism, dedication and commitment to caring for the most vulnerable patients and putting your own personal health at risk. My prayer for all of us is to stay healthy, protect our families and loved ones to the best of our ability, and for warmer weather to come soon and, we hope, end this pandemic. Best wishes.

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Lower Leg Injury  
Tracey Q. Davidoff, MD, FCUCM

A 47-year-old male soccer player was playing in a tournament when he was kicked from behind in the posterior-lateral left lower leg knocking him to the ground. The patient was initially able to weight bear, but in the hours following the injury weight-bearing became more difficult due to pain. He applied ice and took ibuprofen with minimal improvement. He presents to urgent care the following day with bruising and swelling in the area. Examination findings include mild bruising and swelling in the left posterior-lateral calf with point tenderness. There is no swelling distally and no loss of sensation or pulses in the leg and foot. He has full range of motion in the knee and ankle without pain. Weight-bearing is possible but painful and there is a significant limp. The following radiographs are obtained. What is the most likely diagnosis?

A. Rupture of gastrocnemius muscle  
B. Compartment syndrome  
C. Transverse fracture of fibula  
D. Lower leg contusion  
E. Tibial plateau fracture

(Lower Leg Injury article continued on next page)

Tune in to the COVID-19 Listserv to stay apprised of this ever-changing situation

The COVID-19 Listserv was created as a result of the partnership between UCA and CUCM, with the goal of facilitating real-time communications among members during this rapidly-evolving situation. Listserv posts represent the opinion or best practices of the individual posting and need to be verified, but just in the few days since its inception we have seen so many good posts we know you will benefit from following the communications. All members have been added to the COVID-19 Listserv, but if you have not begun to receive those communications, you can request to join the conversation by filling out a brief form on https://www.ucaoa.org/coronavirus
When examined carefully, a non-displaced transverse fracture of the fibular shaft can be seen on the lateral view of the tibia/fibula x-ray.

Rupture of the gastrocnemius muscle is usually due to sudden movement such as pushing off, not direct trauma. There is significant swelling and bruising and the patient cannot weight bear without severe pain and cramping. Compartment syndrome, although sometimes insidious in onset, is usually associated with severe pain, swelling, and at later stages with numbness and loss of pulses. Lower leg contusion would have been the proper diagnosis if the x-ray was normal. Tibial plateau fractures are usually from twisting on planted foot, not from a direct blow. The knee exam would not have been normal with a tibial plateau fracture. This is also not seen on this x-ray.

Transverse fractures of the proximal fibula are usually due to a direct blow. They may be non-displaced or displaced. Depending on mechanism and severity of injury, they may be associated with a tibial fracture as well, which should be ruled out. Displaced fractures should be referred to orthopedics early for possible reduction. Improperly cared for displaced fractures can result in alterations in gait. Because the fibula is non-weight bearing, isolated non-displaced transverse fibular fractures such as this one are very stable and require only conservative treatment with compression, ice, and pain control. A knee immobilizer may be used if necessary. Crutches with weight-bearing as tolerated may be required due to pain. Patients who fail to improve in 8-10 weeks should be referred to orthopedics. Prolonged icing should be avoided as there have been reports of peroneal nerve damage.

Patients can return to sport when callus formation has occurred, usually around 6 weeks. Patients who participate in contact sports may wish to wait a little longer due to pain if struck in the same area.

Clinical Pearls

Cesar Mora Jaramillo, MD

1. Patients should shake and prime inhaler before its first use and after 7 days of it not being used
   a. Note: amount of prime pumps varies by inhaler, i.e. 2 for albuterol and 4 for fluticasone.

2. If using an aerochamber or spacer, ask patient to remove cap of inhaler and attach it to aerochamber (yes, patients might not remove cap)
   a. Shake and then 1 puff. Take 6 breaths and wait at least 1-3 minutes in between puffs to ensure proper drug delivery to lungs. 2nd puff-repeat as directed
   i. As a general rule 4 puffs equal 1 nebulizer treatment for children and 4-8 puffs for adults
   ii. Nebulizers are not recommended for COVID-19 as virus particles aerosolize and are highly contagious. SARS-CoV-2 viral loads in the upper respiratory tract are high. Hence, the virus viability in respiratory secretions including in the form of aerosols is being studied. The virus has been found to be largely stable through a full 180 minutes in aerosols, with only a slight decline at 3 hours.

3. Patient should periodically check the inhaler valve for drug build-up
   a. Often the powder clogs the inhaler valve and blocks medication delivery
   b. If the valve is clogged, patient can disassemble and rinse the holding chamber with warm water and mild soap, dry it, re-prime inhaler and try medication administration again.

4. In a letter published in Lancet Respiratory Medicine, it was proposed that ACE-inhibitors and ARBs could increase the risk for developing severe COVID-19. The coronavirus binds to target cells through the ACE 2, the expression of which is increased when patients take these drugs. There is uncertainty regarding this and, because these medications have known benefits, The American Heart Association, the American College of Cardiology and the Heart Failure Society of America, recommend that patients with novel coronavirus disease (COVID-19) who have underlying hypertension, heart failure, or ischemic heart disease should not stop taking their angiotensin-converting-enzyme (ACE) inhibitors or angiotensin-receptor blockers (ARBs).

5. There’s no widely accepted data about ibuprofen/NSAIDs and COVID-19. However, many credible organizations have advised caution on the matter.
   a. England’s National Health Service drew attention to the following recommendations:
      i. There is currently no strong evidence that ibuprofen can make coronavirus (COVID-19) worse.
      ii. Until we have more information paracetamol is an alternative.
      iii. If patients are taking ibuprofen or another non-steroidal anti-inflammatory (NSAID) on the advice of a doctor, do not stop it.

(Continued on next page)
Anterior shoulder dislocations likely account for nearly 50% of all acute joint dislocations seen in emergency medicine. I remember my emergency department days of wrestling with patients using sheets, weights, multiple staff members and several rounds of opioid medications to pop the shoulder back in. It was time consuming, exhausting, and painful for both the patient and the provider. Enter conscious sedation. Now patients were being sedated with combinations of benzodiazepines, anesthetics, and opioids. This required monitoring by nursing, another provider, or maybe even an anesthesiologist. Easier for the provider, but the patient had to be observed until fully awake, was unable to go back to normal activities for 12-24 hours and took up staff and space in the ED for several hours. This was certainly not a procedure appropriate for urgent care.

Although in more difficult cases conscious sedation may be appropriate, most anterior shoulder dislocations can be easily reduced by just applying a little physics. As a middle-aged rather weak and out-of-shape provider, I would much rather work smart than use brute force. Being able to provide this service in urgent care is also beneficial to our patients, especially during this time of pandemic when non-ill patients should not be spending time in an over-burdened emergency department potentially being exposed to COVID-19.

There are many techniques to reduce shoulders. The two that I have found most helpful in urgent care are the Cunningham technique and the fulcrum or Park technique. Both of these require no sedation and are easy to perform in an urgent care setting. I prefer to premedicate with ibuprofen or ketorolac prior to the initial radiograph, but if the patient is comfortable, or they have had a shoulder dislocation in the past, it is not required. Also keep in mind that these techniques should not be used for posterior dislocations or fractures of the humeral head or glenoid fossa. I will briefly describe the techniques below, but it is best to search for them on YouTube and watch the videos to become more proficient.

I consider the Cunningham technique a form of yoga. In this procedure, the patient is seated in a chair as far back as possible with their back straight up against the back of the chair. The provider is seated facing the patient in another chair or stool on the affected side. Chairs without arms are best. The provider holds the affected arm with the elbow bent and the forearm in pronation with the patient’s hand on the provider’s shoulder. The provider should hold the patient at the elbow crease. Relaxation of the patient is key. I usually ask the patient to close their eyes and visualize a place that is peaceful and relaxing to them, and to let go of all the tension in the body. I ask them to pretend they are melting downward into the floor. Several deep, relaxing breaths should be encouraged. Talking the patient through this is as important as the manipulation. While they are relaxing, the provider massages the trapezius muscle using their opposite hand until it is feeling relaxed. Once this is accomplished, the deltoid is massaged in the same way followed by the biceps. As the muscles relax, slow and steady downward pressure is applied to the elbow crease to encourage the humeral head to move back into the glenoid. If necessary, some external rotation can be provided for encouragement.

The Park or fulcrum technique uses the provider’s fist to act as a fulcrum to move the humeral head back into the glenoid. Again, the patient is seated with the back straight up against a chair or stretcher and encouraged to relax. The elbow is placed at 90 degrees with the forearm in supination. The examiner then places his or her fist as far up into the axilla as possible. Slow and steady pressure is then applied to the mid to distal humerus to encourage the humeral head to pop back into the glenoid fossa. If necessary, an assistant may be used to provide pressure to the scapula which angles the glenoid to a more receptive position. Downward pressure on the opposite shoulder by the assistant may also prevent the patient from rising upwards during the procedure.

Once the shoulder has popped back into place, neurovascular status should be confirmed, a sling or if possible, shoulder immobilizer applied and a repeat x-ray performed to confirm reduction. The patient should be referred to orthopedics for follow-up. Some videos to get you started:

- https://www.youtube.com/watch?v=MkdCGV_MOCM
- https://www.youtube.com/watch?v=9rnadSbqEUC

**References:**

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 only commensurate with the extent of their participation in the activity. Credit 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) though 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. All of the following statements about proximal fibula fractures are true EXCEPT?
   a. Improperly treated displaced fractures may result in an abnormal gait
   b. The fibula is a weight-bearing bone
   c. Over-icing the proximal fibula may result in damage to the peroneal nerve
   d. Transverse fractures of the fibula are usually caused by a twisting motion
   e. Patients with non-displaced transverse fibular fractures can weight bear with crutches if tolerated by the patient

2. What is the percent of children with severe COVID 19 disease?
   a. 2%
   b. 5%
   c. 9%
   d. 12%

3. Which of the following are TRUE regarding shoulder dislocations?
   a. Posterior dislocations are easily reduced using the Cunningham or Park technique
   b. They represent about 80% of all dislocations seen in emergency departments
   c. Conscious sedation is easily performed in the urgent care setting
   d. Once the dislocation is reduced, no further treatment is required
   e. The Park or fulcrum technique uses the provider's fist to act as a fulcrum to push the humeral head back into the glenoid fossa

4. How many priming pumps are recommended for albuterol metered dose inhalers
   a. One
   b. Two
   c. Three
   d. Four

Answers to last month’s questions

1. Evidence supports the use of oral corticosteroids in which of the following?
   a. Pharyngitis
   b. Lower back pain
   c. Bell’s palsy
   d. Bronchitis

2. What is the most important risk factor for psychiatric side effects of oral corticosteroids?
   a. Length of treatment
   b. Type of steroid
   c. Dosage
   d. Age

3. According to the Academy of Breastfeeding Medicine, what advice is recommended for you to provide a lactating mother who potentially has or may have become infected with COVID-19?
   a. Immediately stop breastfeeding and switch the baby to formula
   b. Only offer pumped breast milk to the baby
   c. Continue breastfeeding but wear a mask while breastfeeding and practice good hand hygiene
   d. No recommendations were provided

Which of the following is not an urban legend discussed by Dr. Bhogal to prevent getting COVID-19
   a. Drinking bleach
   b. Eating boiled garlic
   c. High dose Vitamin C
   d. Boric acid inhalation
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.