We Cannot Lose Hope:
As of June 13, 2020, according to the CDC, there are 2,038,344 cases of COVID-19 in the U.S. with the death toll of 114,625. The planet still continues to struggle with this pandemic. Lives still continue to be disrupted. People still continue to struggle with keeping themselves and their loved ones safe. Businesses continue to struggle. Jobless claims continue to be in the millions. While this is clearly not yet over, there continues to be hope that things will improve. The world might never go back to being what it was prior to COVID-19, however, we will come out stronger and smarter.

Our understanding of the virus and the illness continues to evolve. When this illness first came to the horizon a few months back, everyone had very little knowledge about how the illness presents. Our knowledge has since grown, with the clinical presentation becoming clearer to us. Also, we now better understand the complications associated with this illness.

The availability of point of care testing has increased our capability to answer clinical questions in real time. Most urgent care centers are now offering some form of COVID-19 testing for their patients.

The search for a vaccine is in full swing. There are multiple companies and academic organizations working independently or in collaboration to develop a potential vaccine for the SARS-CoV-2 virus. A process that typically would take multiple years, is being expedited at a much faster pace. Some of these trials have shown preliminary hope.

As we continue to battle the SARS-CoV-2 virus and the associated illness, we have to remind ourselves and our teams that hope is what will help us pull through these tough times. Many people around the world are working really hard to find solutions to some tough questions. All this effort towards a common goal will yield positive results. While we keep preparing for the worst, we need to hope for the best.

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

This Fall
As summer is nearly here, it’s a good time to start thinking about the fall. Kids may be back to school. Fear will be lessened by the time since the COVID-19 peak. Strep throat, common colds and, in no time, influenza will be here. Are you ready? Have you thought about the triple threat here? What about the possibility of more than one diagnosis at a time? Will the waiting rooms be full or empty? How will you manage separation while seeing the volume we might expect?

What about prevention?

When should we start the influenza vaccine? How will you encourage patients to protect themselves? What if there is a COVID-19 vaccine? All these questions are tough to answer but we must plan now. Start thinking. Fall will be here soon....
ASIAN TICK FOUND IN AMERICA, SHOULD WE BE WORRIED?
Cesar Mora Jaramillo, MD

When a tick anchors itself into the skin for a leisurely meal, it often spreads germs. It isn't just Lyme disease that we have to worry about! According to CDC, ticks have been shown to carry at least 16 diseases in the U.S alone that can infect humans. Some diseases can be severe such as Lyme disease, babesiosis, Powassan encephalitis, Rocky Mountain spotted fever among others.

The Asian native tick (*Haemaphysalis longicornis*) also known as “longhorned tick” was recently discovered in North America. The tick was first detected in the U.S. on a sheep in New Jersey in 2017. There is only one report of a human victim located in the area of Westchester County, New York. Experts report that in Asia, and in Australia and New Zealand, it is known to spread deadly pathogens to humans and animals. Severe Fever with Thrombocytopenia Syndrome Virus (SFTSV) is a potentially lethal hemorrhagic fever, 12% of cases are fatal. Most common symptoms include fever, vomiting, diarrhea and anemia and in some cases, multiple organ failure can result.

Female longhorned ticks can reproduce without the aid of a male. Asian longhorned ticks have been found on pets, livestock, wildlife, and people. Researchers are looking for these ticks to find out where they live. As of February 7, 2020, longhorned ticks have been found in Arkansas, Connecticut, Delaware, Kentucky, Maryland, North Carolina, New Jersey, New York, Pennsylvania, Tennessee, Virginia, and West Virginia. Certain types of adult ticks are not killed by freezing temperatures and remain active during winter.

For now, the CDC hasn't changed its recommendations for preventing tick bites:
- Use Environmental Protection Agency (EPA)-registered insect repellents containing DEET, picaridin, IR3535, oil of lemon eucalyptus, para-menthane- diol, or 2-undecanone. Always follow product instructions.
- Wear permethrin-treated clothing.
- Shower as soon as possible after spending time outdoors.
- Check for ticks daily. Ticks can hide under the armpits, behind the knees, in the hair, and in the groin.
- Tumble clothes in a dryer on high heat for 10 minutes to kill ticks on dry clothing after you come indoors. If the clothes are damp, additional time may be needed.
- Treat pets and livestock for ticks with veterinarian-approved products.

Patients should be instructed the following:
- Carefully remove any tick as quickly as possible or contact provider for removal.
  - Use fine-tipped tweezers to grasp the tick as close to the skin’s surface as possible.
  - Pull upward with steady, even pressure. Don’t twist or jerk the tick; this can cause the mouth-parts to break off and remain in the skin. If this happens, remove the mouth-parts with tweezers. If you are unable to remove the mouth easily with clean tweezers, leave it alone and let the skin heal.
  - After removing the tick, thoroughly clean the bite area and your hands with rubbing alcohol or soap and water.
  - Never crush a tick with your fingers.
- Save the ticks in rubbing alcohol in a jar or a ziplock bag for identification and consult a provider.

REFERENCES:
Return to play for competitive or highly active persons following COVID infection, a Summary

Tracey Davidoff, MD, FCUCM, Vice President CUCM


https://jamanetwork.com/journals/jamacardiology/fullarticle/2766124

On 5/13/2020 an editorial was published online on *JAMA Cardiology* urging careful consideration before recommending competitive athletes or highly active persons return to activity due to concerns of myocardial injury as a result of COVID-19 infection. These recommendations were compiled by members of the American College of Cardiology’s Sports and Exercise Cardiology Council, with input from national leaders in sports cardiology.

These leaders recognized that significant cardiac morbidity has been observed among patients hospitalized with moderate to severe COVID-19 infection. Up to 22% of these patients may have elevated troponin levels, abnormal ECG findings, and abnormal finding on echocardiography. Myocarditis from myocyte invasion of the virus may result in significant cardiac dysfunction, arrhythmias, and death. For this reason, patients and providers need to be cautious and take a conservative approach when returning to activities such as competitive sport and heavy exercise. As public health restrictions ease and patients return to activities and sports, physicians will be tasked to evaluate and educate these patients in a post-COVID condition.

Evidence-based guidelines are very limited as our knowledge of COVID-19 is rapidly evolving. Guidelines will surely change over time as more information becomes available.

Legend:
COVID-19 Return-to-Play Algorithm for Competitive Athlete and Highly Active People

- **COVID-19:** coronavirus disease 2019; **hsTn:** high-sensitivity troponin I; **RTP:** return to play.
- **a:** Typical testing obtained via a nasopharyngeal swab. All athletes with positive testing should be isolated for 2 weeks regardless of symptoms.
- **b:** If clinical and/or cardiac symptoms develop, follow appropriate clinical pathway.
- **c:** Given lack of clean pathophysiology, we recommend American College of Cardiology/American Heart Association athlete myocarditis guidelines.
HISTORY OF PENICILLIN ALLERGY, IS IT REAL?
Cesar Mora Jaramillo, MD

Commonly, patients that present to urgent care report a history of allergies to penicillin. It is unknown if this has been confirmed or if it is considered a low-risk allergic reaction. Unconfirmed penicillin allergy has been flagged as a public health concern. This has influenced providers’ antibiotic prescription approach for a long time.

In the U.S., penicillin is the most common drug allergy reported and about 10% of the population have been labeled to be allergic. Increased healthcare cost and reported adverse events are caused by the use of alternative non-β-lactam antibiotics. Consequently, the evaluation of penicillin allergy labels is recommended to improve antibiotic stewardship. About 90% of patients who are labeled as allergic to penicillin can tolerate the drug. Many of these patients including the pediatric population are considered low-risk for Immunoglobulin E-mediated hypersensitivity. However, rash or hives in children could be related to bacterial or viral infections and misinterpreted as an allergic reaction when penicillin is administered as treatment.

Penicillin Skin testing has been the standard for evaluating and de-labeling allergic patients. Recent studies have confirmed the safety of clinician-administered oral challenges in low-risk patients, without prior skin testing. Researchers in Australia retrospectively analyzed the records of patients who had undergone skin testing, oral challenge, or both to confirm penicillin allergy. They determined that low-risk history was defined as “benign, immediate (maculo-papular rash, vomiting, diarrhea, pain, fatigue or other somatic symptoms), and delayed rash (without angioedema, mucosal ulceration, or systemic symptoms)”. 97% of the patients tolerated oral challenge and no cases of anaphylaxis were reported.

In addition, a study by Emory University demonstrated that none of the low-risk categorized patients, developed immediate related hypersensitivity reactions to amoxicillin oral challenge.

Patients with histories of severe adverse reactions including Stevens-Johnson syndrome, DRESS (drug rash with eosinophilia and systemic symptoms), acute generalized pustulosis or patients with serum sickness should not be tested and should never receive the drug again. Patients with angioedema or systemic symptoms (e.g., respiratory or cardiovascular) and patients with penicillin-associated rash during the previous year should undergo penicillin skin testing and/or evaluation by an allergist.

American Academy of Allergy, Asthma & Immunology states that most people lose their penicillin allergy over time, including patients with a history of severe reaction such as anaphylaxis. Penicillin allergy testing utilizes a 3-tier testing approach as the gold standard for diagnosing penicillin allergy: 1) performing a percutaneous skin test, 2) more sensitive intracutaneous testing, and 3) an oral drug challenge that ultimately determines if the drug hypersensitivity exists. This is time-consuming and could be painful. De-labeling patients can be achieved by using direct oral amoxicillin challenge and monitoring for 60 minutes after the challenge. The challenge is to increase clinicians’ comfort in administering oral challenges, and to get healthcare systems to support this practice. Recent literature supports the safety and efficacy of direct provocative challenge without preliminary skin testing to exclude penicillin allergy in individuals at low risk.

REFERENCES:

Tune in to the COVID-19 Listserv to stay apprised of the 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. Visit ucaoa.org/coronavirus to view COVID-19 resources and to join the Listserv.
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. Which statement is true when de-labeling penicillin allergic patients?
   a. It should be attempted for all patients with penicillin allergy reactions
   b. Clinicians should monitor patients for 60 min after oral challenge
   c. Every patient with an allergic reaction to penicillin should undergo penicillin skin testing and/or evaluation by an allergist
   d. Penicillin allergy testing utilizes a 4-tier testing approach as the gold standard for diagnosing penicillin allergy

2. Which of the following statements is correct:
   a. Remove a tick by crushing it with fingers
   b. Ticks do not remain active during freezing temperatures
   c. Thrombocytopenia Syndrome Virus has a 12% fatality rate
   d. Tumble clothes in a dryer on high heat for 5 minutes to kill ticks on dry clothing after you come indoors

3. Which of the following does Dr. Bhogal suggest is needed to get through these tough times:
   a. Research
   b. Hope
   c. Attention to detail
   D. Persistence

4. Return to highly competitive activity should be carefully considered after COVID-19 due to concerns about effects on the?
   a. Kidneys
   b. Lungs
   c. Heart
   d. Joints

Answers to last month’s questions

1. Fleischener Society Guidelines suggest chest imaging for?
   a. Asymptomatic patients with close contact exposure to COVID-19 patients.
   b. Chest x-ray imaging is preferred over computed tomography of the chest for COVID-19 patients as first line.
   c. Imaging is recommended for patients with moderate to severe symptoms and for patients who experience respiratory status/symptoms worsening regardless of COVID-19 test results.
   d. Imaging should be considered only with confirmed COVID-19 patients.

2. Which of the following was not a concern related to how Coronavirus has changed urgent care?
   a. Missing other diagnoses when COVID is emphasized
   b. Increased volumes
   c. Patients’ fear causing them to stay home
   d. Overuse of the emergency room

3. Which of the following is true about antibody testing?
   a. IgG antibodies appear first.
   b. Antibodies may take days to develop
   c. These tests are best used for diagnosis
   d. They have no role in assuring immunity

4. Which is true about antigen tests?
   a. They test for the body’s response to the virus
   b. They turn positive first
   c. Sensitivity and specificity are known and certain
   d. They stay positive for life
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.