

URGENT CARE ALERT

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Emergency Physicians and Disclosure of Medical Errors

ABSTRACT & COMMENTARY

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Dr. Shufeldt reports no financial relationship to this field of study.

Synopsis: Examines the issue of disclosure of medical errors and the barriers to error reporting.

Source: Moskop JC, et al. Emergency physicians and disclosure of medical errors. *Ann Emerg Med.* 2006;48:523-531.

SINCE THE PUBLICATION OF THE INSTITUTE OF MEDICINE'S "To Err is Human," increased attention has been given to medical error reporting. This article reviews medical error disclosure in emergency medicine, suggests the rationale for error reporting, and examines barriers to medical error disclosure. Medical error is defined as, "failure of a planned action to be completed as intended or the use of a wrong plan to achieve an aim." Medical errors do not necessarily mean that the patient has been harmed.

Physicians have a duty of truthfulness. The American Medical Association's "Principles of Medical Ethics" includes the principle that "a physician shall. . .be honest in all professional interactions. . ." What information is owed to the patient? One source of guidance can be found in the legal doctrine of informed consent. This doctrine can be summarized in the following manner. What a reasonable person would need or want to know in order to make an informed decision about his/her medical treatment. This also can be extended to error reporting. What information would a reasonable person want to know about a medical error that occurred during his/her treatment? If the error is minor or quickly identified and corrected, a physician may still want to inform the patient about this inconsequential error and provide reassurance that the error has been identified and that no untoward outcome occurred. This also extends to reporting errors made by another physician. The American College of Emergency Physicians is

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silent on disclosing errors made by another physician. However, physicians should not simply ignore errors committed by peers. At minimum, they should discuss the situation with the offending physician. If the patient asks specific questions about the reason for complications, the physician should not withhold information.

There are numerous barriers to medical error reporting. The US health system is not designed to reward or encourage error reporting. Both health care institutions and health care providers have a strong interest in avoiding medical liability exposure and, consequently, may view error reporting as a liability risk.

The distinctive environment of the emergency department has its own barriers to error reporting. High patient volume, high acuity, short duration of ED stay, and the episodic nature of the interaction increase the risk of errors and may foreclose their identification and reporting. For a variety of reasons (incomplete or false contact information, out of town visitors, fugitives, and undocumented immigrants), physicians may have difficulty contacting ED patients. Even if the patient is found, physicians may lack the training or skill set to discuss medical errors with patients. Many physicians believe, despite evidence to the contrary, that disclosing errors further erodes patient trust in them, in particular, and the medical profession in general.

The threat of malpractice liability looms large in the physician's mind and is a significant barrier to error

reporting. In an effort to overcome any potential liability of a physician's apology, 18 states have enacted statutes making a physician's apology inadmissible in a civil suit. One caution, however, is that most state's "I'm Sorry Statutes," only protect a physician's expression of sympathy for the patient, not an admission of fault.

Disclosure of errors is important but it is only one piece of a comprehensive approach to error reduction in medicine. In addition to disclosing errors, institutions and physicians must work to reduce the number of errors that occur. Administrative staff should promote a culture of error reporting. For example, an institution might establish a safety hotline to encourage error reporting. Once an error occurs, the root cause of the error should be investigated in an effort to prevent reoccurrence.

Physicians should practice disclosing minor mistakes with little or no impact since, by doing so, they will acquire the skills necessary to admit consequential errors. "The virtue of truthfulness is the habit of telling the truth even when it is inconvenient or involves some personal risk. When professionals develop a habit of telling the truth, every truth told strengthens their inner selves. . . the virtue of truthfulness is ultimately essential for an effective professional-patient relationship because relationships cannot endure failures of truthfulness for long."

■ COMMENTARY

This article is particularly relevant to urgent care (UC) medicine inasmuch as many of the barriers to error reporting in emergency medicine are similar to those that exist in urgent care medicine. For example, many patients in an urgent care environment are treated only one time, spend a short time in the clinic, and may be difficult to follow once care in the center is completed. Moreover, UC physicians often do not have an ongoing relationship with the patient or their family, nor do most errors become visible while the patient is in the UC.

The urgent care setting is a place where errors can occur and a place where the errors of other may be discovered. UC physicians should follow the doctrine of informed consent and respond to errors with the reasonable person perspective; what would a reasonable person want to know about their medical condition or complications that ensue from medical error? By using the legal doctrine of informed consent, UC physicians will respond appropriately and ethically to their medical errors and the errors of others. ■

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Testicular Torsion

ABSTRACT AND COMMENTARY

By Rene J. Beckham, MD

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Dr. Beckham reports no financial relationship to this field of study

Synopsis: *Overview of diagnosis and treatment of testicular torsion.*

Source: Ringdahl E, Teague L. Testicular Torsion. *Am Fam Physician.* 2006;74:1739-1743.

TESTICULAR TORSION OCCURS MOST FREQUENTLY IN males age 25 and younger and has an incidence of 1 in 4000 annually.¹ There are multiple predisposing factors to testicular torsion; however, it most commonly occurs without any precipitating event.² The mechanism of injury in testicular torsion is the rotation of the spermatic cord causes vascular obstruction which leads to testicular ischemia. The ischemia can occur anywhere from within 4 to 24 hours, depending on the degree of rotation; however, in the majority of cases it occurs within 6 hours.³ Testicular torsion is a medical condition that must be diagnosed quickly and without delay in surgical intervention, or there is risk of testicular viability.

When evaluating a patient with scrotal or testicular pain, the following differential diagnosis should be considered: trauma, epididymitis/orchitis, incarcerated hernia, varicocele, idiopathic scrotal edema, and torsion of the appendix testis (remnant of the mullerian duct at the superior pole of the testis). There are some findings on physical exam which are more specific in testicular torsion than in the aforementioned conditions. Venous congestion usually causes the affected testis to be enlarged, and the shortening of the spermatic cord may cause the testis to appear higher on the affected side. Both of these are very specific to testicular torsion. The location of the epididymis on palpation will vary depending on the degree of torsion and whether there is an absence of the cremasteric reflex.

Any patient evaluated within 6 hours of onset of pain, with a history and physical exam which are highly suspicious for torsion, should have immediate surgery. Detorsion in this time frame has been found to have a testicular salvage rate of 90%, whereas the salvage rate falls rapidly after 6 hours, and is only 10% at twenty-four hours.⁴ Any patient with a questionable exam, or who falls outside the 6-hour window, should have a diagnostic test. The 2 most specific tests are a Doppler

ultrasonography, which evaluates blood flow in the testis and can differentiate ischemia from inflammation and other testicular disease and scintigraphy using technetium, which reveals a decrease in delivery of the radiotracer to the ischemic testis. The benefit of scintigraphy is that it has a 100% sensitivity for testicular torsion compared to an 88% sensitivity with the Doppler ultrasonography. However, the Doppler is more readily available in most medical centers, and therefore, will lead to a more rapid diagnosis.^{5,6}

There have been cases with successful treatment of testicular torsion by manual detorsion; however, this maneuver should never delay a surgical consultation. Surgical exploration is the definitive treatment for testicular torsion and may include correction of the torsion if the testis is viable and bilateral orchiopexy to prevent future torsion or removal of the testis if it is not viable and orchiopexy to the opposite side. Loss of a testicle leads to the most significant complication in testicular torsion. There is a high risk of litigation with a missed or delayed diagnosis of testicular torsion, even when the cause for the delay is due to late presentation of the patient to a medical facility.

■ COMMENTARY

Anyone working in an urgent care setting should be aware of the urgency needed in diagnosis and treatment in young males who present with testicular pain. A history of testicular trauma should not limit the suspicion and appropriate work-up to rule out testicular torsion. The age of the typical patient with torsion, and the ultimate consequence, make this a devastating problem if the diagnosis is missed or the patient is treated inappropriately.

Each patient should initially have a thorough history and physical exam and be referred quickly if there is any suspicion of testicular torsion. A call should be placed directly to a surgeon, if possible, or the emergency physician who will be accepting the patient. The patient and family must be educated on the possible diagnosis, treatment, and consequences so that they are aware of the urgency of the situation. It is not possible to control how or when patients present for care; however, once a patient with a history or exam presents to the urgent care they should be treated with urgency to prevent any further delays in treatment. ■

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You Put What Where?

ABSTRACT & COMMENTARY

By John P. Santamaria, MD

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Dr. Santamaria reports no financial relationship to this field of study

Synopsis: *A retrospective case series looking at the success and complication rates of otic foreign body removal.*

Source: Marin JR, Trainor JL. Foreign body removal from the external auditory canal in a pediatric emergency department. *Pediatr Emerg Care*. 2006;22:630-634.

CHILDREN ARE OFTEN BROUGHT TO MEDICAL ATTENTION for removal of foreign bodies lodged in the external auditory canal. Most studies of this topic are found in the otolaryngology literature, emphasizing high ENT referral rates and frequent need for operative removal. Marin and colleague reviewed the emergency department literature, noting wide ranges of successful removal (7-78%) and complications (2-47%).

In this retrospective case series, attempts to remove 254 foreign bodies from 250 children were made. Although there were 55 unique foreign bodies, most were beads, insects, cotton and paper. Fifty patients had unsuccessful removal attempts prior to ED arrival, most having been referred to the ED by a primary care physician or subspecialty clinic.

Only 1 of 250 children received conscious sedation in the ED. Eighty percent of foreign bodies were successfully removed in the ED; the remaining 20% were referred to an otolaryngologist. Half of the referred patients did not have any foreign body removal attempt in the ED owing to prior unsuccessful attempts, prior patient relationship with the subspecialist, refusal to allow ED examination, or ED physician discretion. Of

those receiving ENT consultation, almost a third had removal in the operating room.

Complications were mostly minor, including 29 children with canal bleeding and/or laceration. One child had TM rupture, ossicle damage, and subsequent hearing loss. In this case, the child struggled during numerous attempts to remove a piece of styrofoam using suction and alligator forceps.

Multiple attempts, and more than one instrument used for removal, were independently associated with both failed removal and complications. Although contrary to findings in previous studies, Marin et al did not find higher rates of failure in cases involving patients under 4 years of age or patients with foreign bodies present for more than 24 hours.

All batteries, sticks, and rubber objects were removed successfully. Insect foreign bodies were removed in only 65% of cases; Marin et al hypothesize that the success rate may have been higher had irrigation been used. Higher complication rates were found when removing erasers and pieces of foam.

Limitations of this study were cited, including the retrospective design, possible overestimate of the complication rate, and incomplete chart information. The chart did not routinely include documentation of the instrument used to successfully remove the foreign body or the level of physician training and experience.

■ COMMENTARY

First, anyone practicing medicine in an urgent care center should expect and be prepared to see children with foreign bodies in the ear canal, nose, and GI tract. Although it is a retrospective study with several limitations, this article brings up much food for thought.

- Should otic foreign body removal be attempted in my facility?
- Can we predict success with a screening history and physical examination?
- What additional skills (physician, staff) and equipment are necessary?
- If not, to whom will these patients be referred?
- Will the subspecialist see my patient in a timely manner?

As in most things medical, there is no right answer that fits every situation. Physicians need to know their limitations and not tread in areas where they are more likely to do more harm than good. This requires an honest assessment of one's skills, as well as patient characteristics. The physician without experience or training in this area is no match for the completely uncooperative toddler with a rubber eraser in his ear.

However, this is not an excuse for inaction. It is a call to action. Often, with only a modest amount of

training and minimal equipment, the physician can successfully remove many pediatric foreign bodies. An important aspect of preparation is education of the staff in using age-appropriate immobilization and distraction techniques.

Do heed the warnings, though, about multiple attempts and use of a variety of instruments, both of which will increase the chance of bleeding and make removal by the otolaryngologist more difficult. And always review the risks of the procedure with the patient and family, as they may opt for ENT consultation.

One other tip — when a child presents with an otic foreign body, always check the nose and other ear for second, third, and fourth foreign bodies. You and the parents may be surprised by what you find. ■

Erythema Multiforme

ABSTRACT & COMMENTARY

By John Shufeldt, MD, JD, MBA, FACEP

Synopsis: *Overview of the diagnosis and treatment of erythema multiforme*

Source: Lamoreux MR, et al. Erythema multiforme. *Am Fam Physician.* 2006;74:1883-1888.

ERYTHEMA MULTIFORME (EM) IS A SELF-LIMITED hypersensitivity reaction which is often recurring. It is associated with both infectious processes and certain medications. The common infections associated with EM are Herpes Simplex virus 1 and 2 (HSV), *Mycoplasma pneumoniae*, and fungal infections. Common medications that can cause EM are barbiturates, hydantoins, NSAIDs, penicillins, phenothiazines, and sulfanomides. EM was previously thought to be part of a spectrum of diseases which included erythema multiforme minor, Stevens-Johnson syndrome (SJS), and toxic epidermal necrolysis (TEN). EM is now thought to be a distinct condition since it is characterized by minimal mucosal involvement and infrequent epidermal detachment.

EM often occurs in adults between the ages of 20-40 years old. The most common cause is HSV, which accounts for more than 50% of the cases, followed by mycoplasma and fungal infections. There have also been reports of EM caused by vaccines (DT, Hep-B, and small pox). Other medications (Cipro, Wellbutrin, and Glucophage) and other viruses (varicella zoster, Hep-C, CMV, and HIV) have also been linked to EM.

HSV is often the culprit in recurrent EM. Of note, most patients with HSV infection do not develop EM, and patients with EM caused by HSV often do not have a clinically apparent outbreak of HSV.

The rash associated with EM usually appears distally and spreads proximally. The patient may experience cutaneous purities prior to the rash appearing. The rash begins as sharply demarcated macules that become papular. The characteristic target lesion has a smooth edge with distinct zones. An outer peripheral ring, a lighter inner zone, which may appear pale or pink, and a dark reddish center. These characteristic lesions may not appear for several days when lesions of different morphology are present, hence the name multiforme.

EM is usually a clinical diagnosis. Skin biopsy is not indicated when the lesions are consistent with their typical morphologic pattern and/or when the patient has a coexisting HSV infection. In cases where the rash is not typical or where it is recurrent and without a documented HSV infection, biopsy by a dermatologist may be indicated. The differential diagnosis for EM includes urticaria, viral exanthems, vasculitis, pityriasis rosea, lupus erythematosus, drug reaction, and other hypersensitivity reactions.

Typical cases of EM do not require treatment other than symptomatic relief with oral antihistamines and topical steroids. In patients with a coexisting HSV infection, treatment with oral acyclovir, valacyclovir, or famciclovir is indicated and will decrease the number of lesions and the duration of the disease. Oral prednisone has also been used; however, it may lower the patient's resistance if they have a coexisting HSV infection. Recurrent EM may be treated with one of the aforementioned antiviral agents, even when HSV is not an obvious precipitating factor. In those patients who have recurrent EM despite aggressive therapy, dermatological consultation is warranted.

■ COMMENTARY

EM is a frequent diagnosis in the urgent care setting. Often, the offending medication or pathogen is not easily identified. In these patients, the standard of care is to document that no clear pathogen is identified, to identify and refer those patients who are at risk for SJS and TEN, and to treat the patient symptomatically. In patients with a coexisting HSV infection, the use of an oral antiviral medication is indicated. I would not place the patient on oral steroids since there has never been a controlled study which has shown that oral steroids are effective in ameliorating the rash of EM. ■

Sleep Deficit: The Performance Killer

ABSTRACT & COMMENTARY

By John Shufeldt, MD, JD, MBA, FACEP

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Dr. Shufeldt reports no financial relationship to this field of study.

Synopsis: A discussion about the dangers of sleep deprivation.

Source: Czeisler CA. Sleep deficit: The performance killer. *Harv Bus Rev.* 2006;84:53-59.

MORE THAN 1.35 MILLION AUTO ACCIDENTS IN the last 5 years have been caused by driver fatigue. The effect of sleep deprivation on cognitive performance has been well documented; when an individual has been awake for more than 18 hours, reaction speed, short-term and long-term memory, ability to focus, decision making ability, math processing, and spatial orientation all suffer. Sleep deprivation has even been linked to high blood pressure and obesity.

Encouraging a culture of sleeplessness is downright dangerous and antithetical to intelligent management. Most corporations have policies about drugs, drinking, and sexual harassment; however, they often push employees to the brink of self-destruction by encouraging a level of sleep deprivation, with a resultant impairment every bit as risky as intoxication. Therefore, managers, owners, and clinicians have a societal responsibility to take sleep deprivation seriously.

Four major sleep-related factors affect cognitive performance. The first major factor is the body's homeostatic drive for sleep at night. Throughout the day, humans build up a stronger and stronger drive for sleep until at some point the sleep switch ignites. Once that happens, a person only has a few seconds before they are asleep. So, if they are driving, flying, or with a patient, they just have a few seconds to respond to the brain's automatic shut-off.

The second major factor has to do with the total amount of sleep you get over several days. If you get at least 8 hours of sleep, your level of alertness should remain stable throughout the day; however, if you have a sleep disorder, or get less than 8 hours for several days in row, the sleep deficit you start to build up will make it more and more difficult for the brain to function. Individuals who average 4-5 hours of sleep for

several nights in a row have the same level of cognitive impairment as those who have been awake for 24 hours in a row, which is also the same level as an individual who is legally intoxicated.

The third factor has to do with the circadian pacemaker, which is the body's neurological timing device for sleep. Oddly enough, for reasons that are still not understood, it works in opposition to homeostatic drive. The pacemaker sends out its strongest signal for sleep just before we wake up and its strongest drive for wakefulness about 2-3 hours before the homeostatic drive for sleep peaks. These 2 competing factors work in harmony to give us a restful night of sleep and a level of alertness throughout the day.

The fourth and final factor is what is called sleep inertia. The brain is like a car engine that needs time to warm up before running at peak efficiency. Typically, this warm-up takes between 5 and 20 minutes. You do not want to make important decisions before your brain has the time to warm up. Remember when the nurse woke you up on-call during residency? Do you really think they listened to the answer you gave them? Thank God they didn't listen to me when they woke me up at 3am!

Sleep also becomes more difficult over the age of 40. Indeed, the risk of sleep disorders increases over the age of 40. Many people gain weight as they age, which may precipitate sleep apnea (the cessation of breathing during sleep). Sleep deprivation also reduces an individual's ability to metabolize glucose and increases the production of the hormone ghrelin, which makes people crave carbohydrates that can cause weight gain and may increase the risk of sleep apnea. Some researchers postulate that the epidemic of obesity in America may be related to chronic sleep deprivation.

In one study on interns, those that had been awake for 24 hours or more had a 61% increase in risk of stabbing themselves with a needle or scalpel and a 168% increase in risk of being involved in a car accident. Today, some states include sleep deprivation of more than 24 hours in their definition of recklessness.

Companies should focus on educating their workforce on sleep and the problems associated with sleep deprivation. Policies should also limit the number of hours worked in a day and the total number of hours worked in a week. More sleep equates to better performance, a healthier lifestyle, and a safer and more productive workforce.

■ COMMENTARY

You may wonder why I included a *Harvard Business Review* article in *Urgent Care Alert*. For those of us who have lived through the years of sleep deprivation associated with medical residency and shift work, the reasons for including this topic are self-evident. Sleep deprivation

is a major contributing factor in medical error. As physicians and managers, we should work to improve the sleep patterns of our colleagues and employees, if for no other reason than to protect our patients.

Gone are the days of “I suffered through it during my training, so you must do it during years.” As health care professionals, we must treat ourselves and our colleagues with the same level of diligence and intelligence we reserve for our patients. ■

Ankle Sprains: Medical Management Options

ABSTRACT & COMMENTARY

By Matt Shores, MD

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Dr. Shores reports no financial relationships relevant to this field of study.

Synopsis: *Acetaminophen at 1300 mg tid is no less effective than Ibuprofen 400 mg tid in treating acute ankle sprains.*

Source: Dalton JD Jr, Schweinle JE. Randomized controlled noninferiority trial to compare extended release acetaminophen and ibuprofen for the treatment of ankle sprains.” *Ann Emer Med.* 2006;48:615-623.

IN EMERGENCY DEPARTMENTS, URGENT CARE CENTERS, and family medicine offices across the country, ibuprofen is a mainstay in the treatment of acute ankle sprains. After all, ibuprofen is cheap, fairly well tolerated, available over the counter, and a proven success in treating pain and inflammation. However, it is not the only option. In a November 2006 article published by the *Annals of Emergency Medicine*, Dalton and colleagues set out to prove that the use of acetaminophen was not inferior to the use of ibuprofen in the treatment of acute ankle sprains.

In this study, a randomized, double-blind, parallel-group study, patients with acute ankle sprains were evaluated in a wide variety of settings, including urgent cares, and were randomized to either receive acetaminophen 1300 mg tid or ibuprofen 400 mg tid for the treatment of their ankle injury. Only patients with grade I or grade II ankle sprains were included in the study. Ankle sprains were graded using the Leach classification:

- Grade I ankle sprain presents as stable, with a partial tear of ATF, intact CFL, negative anterior drawer

test, and negative talar tilt test;

- Grade II ankle sprain presents as stable, with a complete tear of ATF, with or without a partial tear of CFL, a positive anterior drawer test, and a negative talar tilt test;

- Grade III ankle sprain presents as unstable, with a complete tear of both ATF and CFL, a positive anterior drawer test, and a positive talar tilt test.

Two hundred and sixty patients were evaluated using a visual analog scale (VAS). Follow-up was scheduled for day 4 and day 9 status post treatment initiation. The primary end point in this study was pain, with walking on day 4 as a change from the baseline assessed by the patient using VAS. Secondary end points included pain with walking on day 9, as well as changes from baseline on day 4 and 9 in various categories, including ability to walk, ankle swelling, ankle bruising, range of motion in the ankle, overall satisfaction of treatment, percentage of patients with positive anterior drawer test, and total time back to normal activity.

The primary end point of pain of walking on day 4 resulted in a change from baseline of 35.78 (using VAS) in the acetaminophen group and 36.46 in the ibuprofen group. On day 9, the change from baseline on pain with walking was 54.37 in the acetaminophen group and 59.51 in the ibuprofen group. Each of the secondary end points produced similar results. The study ultimately concluded that acetaminophen taken at 1300 mg tid was not inferior in treating ankle sprains than ibuprofen 400 mg tid.

■ COMMENTARY:

Ankle sprains are a large contributor to patient visits at healthcare centers across the nation. It is estimated that one million ankle sprains present each year.¹ As detailed above, the evaluation of ankle sprains stratifies injuries into grade I, II, or III injuries.

The mainstay of treatment for ankle sprains, particularly grades I and II, is RICE therapy: rest, ice, compression, and elevation. Ivins details the PRICE theory, adding protection to the RICE foundation.² In addition, whether physician driven or patient driven, the use of medications in treating ankle sprains is often times a foregone conclusion.

The purpose of this study is to determine whether acetaminophen is inferior to ibuprofen in the treatment of acute grade I or grade II ankle sprains. In order for this comparison to have relevance, it must be known that ibuprofen at 1200 mg/day is superior to placebo in treating ankle sprains; this was done by Moran in 1991.³ In the end, Dalton et al accomplish what they set out to do; they demonstrate that 1300 mg of acetaminophen tid is comparable to 400 mg of ibuprofen tid in expediting the recovery from ankle sprains. By no means does

this relegate ibuprofen to the proverbial bench; it simply adds acetaminophen as an effective alternative to NSAIDs in treating ankle sprains when NSAIDs may be contraindicated in certain patients. In addition, acetaminophen and ibuprofen are not the only options when it comes to effectively treating ankle sprains.

In a literature search, ibuprofen and various anti-inflammatory medications have been studied in the treatment of ankle sprains. In Moran's 1991 study, diclofenac potassium was shown to be superior to ibuprofen in the treatment of ankle sprains and, in turn, ibuprofen was superior to placebo.³ Multiple studies have taken a look at cox-2 inhibitors such as celecoxib. In a 2001 study by Ekman and colleagues, it was shown that celecoxib at 200 mg bid allowed for a return to function in 5 days, as opposed to ibuprofen at 800 mg tid, which allowed for return to function in 6 days; both were superior to placebo, returning function in 8 days.⁴ Petrella and colleagues, in 2004, analyzed the efficacy of celecoxib (200 mg bid) vs naproxen (500 mg bid) in the treatment of ankle sprains; they demonstrated that celecoxib was not inferior to naproxen, and celecoxib produced less dyspepsia as an adverse effect than naproxen.⁵ In regards to recent fears surrounding cox-2 inhibitors, in January of 2007, in the *American Journal of Cardiology*, White and colleagues performed the largest meta-analysis on the risk of cardiovascular side effects related to celecoxib, and failed to demonstrate increased risk for cardiovascular events vs placebo.⁶

In conclusion, multiple studies have proven the efficacy of anti-inflammatory medications in the treatment of ankle sprains. In many urgent care facilities, emergency departments, and primary care offices, the mainstay of treatment is ibuprofen 1200-2400 mg/day or naproxen 500 mg bid. Both medications have proven to be effective vs placebo and, in the right patient populations, are very well tolerated.^{3,5} As an alternative to these medications, physicians should feel comfortable exploring other options. As demonstrated in this featured study, acetaminophen is a safe (OTC) alternative to NSAIDs and is just about equal in efficacy to ibuprofen in treating ankle sprains.¹ In addition, cox-2 inhibitors, such as celecoxib, may be superior to medications like ibuprofen and naprosyn.^{4,5} Ultimately, every physician must make a choice based on their own comfort level as they assess each patient's individual risk and needs. Of course, it's nice to know there are multiple effective options. ■

References

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CME Questions

5. **True or False? "I'm Sorry Statutes" in most states only protect a physician's expression of sympathy for the patient, not an admission of fault.**
 - a. true
 - b. false
6. **What differential diagnoses should be considered in evaluating a patient with scrotal or testicular pain?**
 - a. trauma
 - b. incarcerated hernia
 - c. torsion of the appendix testis
 - d. All of the above
7. **Which medications can cause erythema multiforme?**
 - a. barbiturates
 - b. penicillins
 - c. NSAIDs
 - d. All of the above

Answers: 5. (a) (d) 6. (d) 7. (d)

CME Objectives

- The objectives of *Urgent Care Alert* are to:
- quickly recognize or increase index of suspicion for specific conditions;
 - apply state-of-the-art therapeutic techniques to treat patients with particular problems;
 - identify both common and rare complications that may occur. ■