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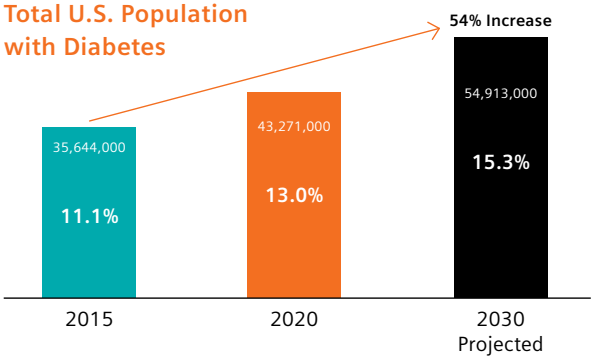
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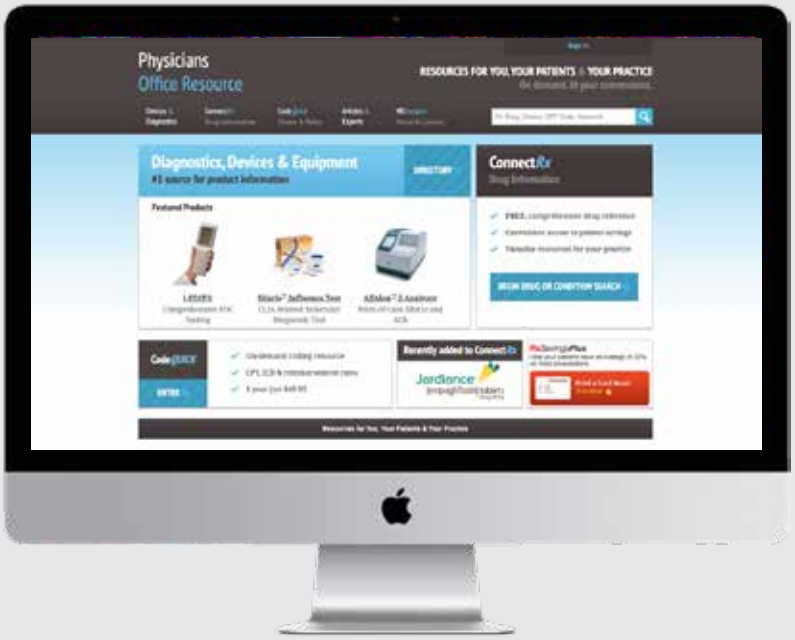
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PUBLISHED BY
Medical Education Resources, LLC

PUBLISHER
Aaron R. Medaris
amedaris@physiciansofficeresource.com

CEO
Andrew C. Nimmo
acnimmo@physiciansofficeresource.com

PRESIDENT
John D. Pasquale
jpasquale@pharmaconnect.com

BUSINESS MANAGER
Marci J. Hills
mhills@physiciansofficeresource.com

TRAVEL EDITOR
Brandi L. Brower

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How Point-of-Care Testing Impacts Parental Satisfaction

Rapid results reduce uncertainty, but only when testing is appropriate, accurately performed, and paired with communication.

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FEATURE

Antigen vs Molecular Testing:

CHOOSING THE RIGHT TOOL FOR THE RIGHT PATIENT

BY RYAN SIMEONE, SEKISUI DIAGNOSTICS

For primary care practices, respiratory season often begins with a familiar problem: overlapping symptoms. Fever, cough, fatigue, myalgia, sore throat, and congestion may reflect influenza or COVID-19; similar signs and symptoms can also occur with other respiratory viruses or noninfectious conditions.[5,6] Because symptoms alone rarely identify the cause with certainty, the question is not simply whether to test. It is which test can provide a useful answer for the patient, the clinician, and the workflow of the visit.

Rapid antigen and molecular tests can both support timely outpatient decision-making, but they do so in different ways. Each method detects a different target, carries different implications for sensitivity and interpretation, and fits differently into practice operations. Choosing well requires attention to clinical context, including the patient's risk, timing of illness, likelihood of infection based on symptoms and exposure, potential consequences of a missed infection, and the need for a same-visit result.

Understanding What Each Method Detects

Antigen tests detect viral proteins. In outpatient respiratory testing, many rapid antigen assays use lateral-flow immunoassay technology to identify viral antigens from respiratory specimens.[7,8] Because the target is not amplified, the specimen must contain enough viral antigen for the assay to detect it.[7]

That feature explains much of antigen testing's value and its limitations. Antigen assays can be fast, accessible, and relatively simple to perform, making them useful when the result is needed during the office visit.7 However, a negative antigen result does not always exclude infection, particularly when symptoms, exposure history, or local disease activity suggest that infection remains clinically likely.[7,9,10]

Molecular tests detect viral nucleic acid. These include polymerase chain reaction and other nucleic acid amplification technologies, such as reverse transcription loop-mediated isothermal amplification. Amplifying the genetic target enables molecular methods, including nucleic acid amplification tests (NAATs), to detect viral RNA or nucleic acids with high sensitivity and to be more likely than antigen tests to detect respiratory viruses in respiratory specimens.[6,9,11]

At the same time, "molecular" should not be understood as synonymous with off-site laboratory testing or delayed turnaround. Compact platforms now allow some molecular assays to be performed at the point of care. Result time, instrument requirements, throughput, complexity, and cost still vary by system, so operational fit remains part of the decision.

Match the Testing Strategy to the Patient

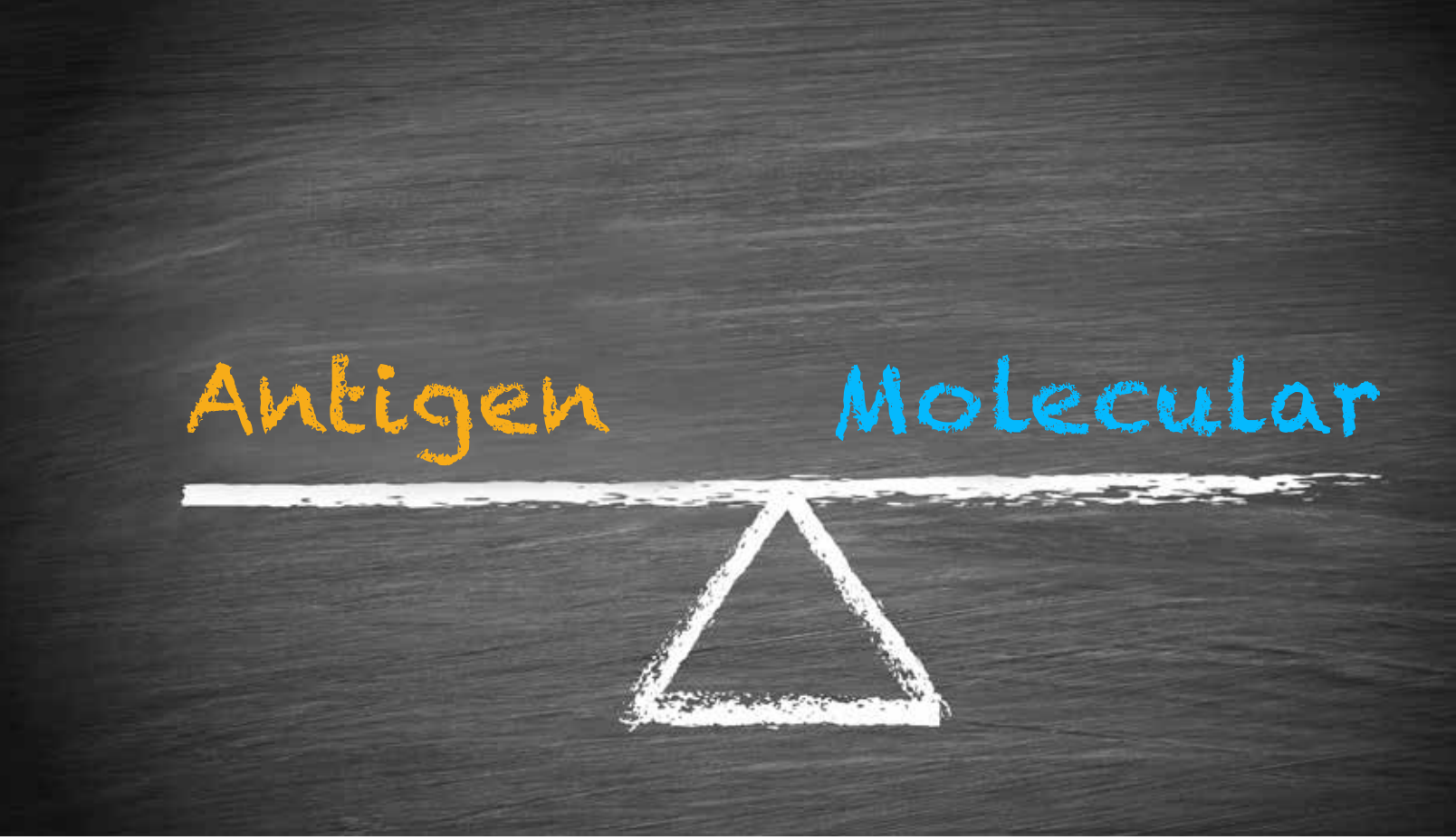
A practical testing decision begins with three questions.

1. How likely is infection based on symptoms, exposure, and current respiratory virus activity?

This assessment reflects symptoms, known exposure, duration of illness, local disease activity, and other epidemiologic information.[5,6,7] When infection appears less likely, a negative antigen result may be adequate for many routine outpatient decisions. When infection remains likely, the possibility of infection may remain despite a negative antigen result, and repeat or molecular testing may be appropriate depending on the situation.[7,9,10]

2. What are the consequences of missing the diagnosis?

The answer differs for a healthy young adult with mild ill-



ness and an immunocompromised patient or older adult at increased risk of complications.[5] If failing to detect infection could delay time-sensitive treatment, expose vulnerable contacts, or materially change the care plan, molecular testing may offer greater clinical value because molecular tests are generally more sensitive than antigen tests for respiratory virus detection.[6,9,11]

3. How quickly must the result be available?
The most analytically sensitive test is not always the most useful if the result arrives after the treatment or follow-up decision must be made. Conversely, the fastest test may not provide enough reassurance when the clinical stakes are high. CDC notes that rapid molecular influenza assays can provide results in approximately 15–30 minutes, while antigen tests typically provide rapid results but are generally less sensitive than NAATs.[7,11]

Point-of-care coordinators should evaluate total turnaround time rather than assay run time alone. Specimen collection, staff availability, test setup, quality-control requirements, documentation, result reporting, cleaning, and patient communication all influence the actual workflow.

When Antigen Testing Fits the Clinical Need

Antigen testing may be a practical first-line choice for a symptomatic patient who presents during the acute phase of illness, when viral burden is more likely to be detectable. A rapid result can support same-visit conversations about treatment, infection precautions, work or school attendance, and follow-up.

Speed is especially useful when the result may change the immediate plan. During periods when influenza and COVID-19 circulate at the same time, a combination assay can help distinguish infections that may look similar at presentation.[5,6]

The OSOM® Flu COVID-19 Combo Test, for example, is a lateral-flow immunochromatographic antigen assay that simultaneously detects and differentiates influenza A, influenza B, and COVID-19 proteins from an anterior nasal swab. The test produces results in 10 minutes and is authorized for point-of-care use in CLIA-Waived settings.[1]

In general, a positive antigen result can provide useful evidence that the detected virus is present. A negative result, however, should be interpreted in the context of symptom duration, exposure history, local prevalence, and the patient's risk profile because viral antigen levels may be below the assay's detection threshold.

For antigen assays, some products may specify that negative results are presumptive and should be confirmed with a molecular assay when necessary for patient management. Negative antigen results should not serve as the sole basis for treatment, infection-control, or other management decisions.1

Antigen testing, therefore, should not be framed as universally inferior. It is a different diagnostic tool whose clinical value depends on timing, patient selection, disease prevalence, and how the result is used.

When Molecular Testing May Be Preferred

Molecular testing may be preferred when greater analytical

sensitivity is needed or when the clinical consequences of a false-negative result are substantial.[6,9,11]
For example, an older adult with cardiopulmonary disease who presents with respiratory symptoms and a known household exposure may need a testing approach that provides more reassurance after a negative result. CDC guidance notes that older adults and people with certain underlying medical conditions are at higher risk for severe influenza or COVID-19 and that testing can help guide treatment decisions when these viruses are suspected.[5] In that context, a negative antigen result may be less reassuring than it would be in a lower-risk patient when infection remains clinically likely.[7,9,10]

Molecular testing may also be appropriate when:

- Symptoms and exposure history strongly suggest infection despite a negative antigen result.[7,9,10]
- A more sensitive result is important for a high-risk or immunocompromised patient.[5,9,11]
- The patient presents at a point in illness when antigen levels may be lower, increasing the chance that a single antigen test could miss infection.[7,10]
- The anticipated clinical action justifies the additional time or resources associated with molecular testing, such as antiviral treatment, infection-control decisions, or additional diagnostic evaluation.[5,6,9]
- The practice wants an initial molecular answer rather than an antigen-first testing pathway, particularly when test sensitivity is a key priority for patient management.[6,7,9]

The Metrix® COVID/Flu Test provides an example of point-of-care molecular testing. It uses reverse transcription loop-mediated isothermal amplification to detect and differentiate COVID-19, influenza A, and influenza B nucleic acid from an anterior nasal specimen.2 The system provides results in 20 minutes, requires no maintenance or calibration, and can be used in a CLIA-waived setting.[4]

Molecular testing can reduce some forms of diagnostic uncertainty, but it does not eliminate the need for clinical judgment. No respiratory test result should be interpreted apart from the patient in front of the clinician.

Build a Testing Pathway

Practices do not need to select one methodology for every patient. A tiered pathway can use both technologies according to clinical need and operational capacity.

One approach is to use a multiplex antigen assay for eligible symptomatic patients when an immediate result is the priority. Positive findings can then be interpreted with the patient's history and presentation. If the antigen result is negative but suspicion remains high, the practice can escalate to point-of-care molecular testing or send a specimen for laboratory-based testing, depending on available resources.

Another approach is to begin with molecular testing for high-risk patients, patients whose treatment decisions require a more sensitive initial result, or situations in which follow-up would be difficult.

Protocols should specify:

- Patient eligibility and authorized specimen types
- Appropriate timing relative to symptom onset
- Circumstances requiring serial or confirmatory testing
- Escalation criteria after a negative antigen result
- Documentation and result-reporting responsibilities
- Quality-control procedures
- Staff competency and retraining requirements
- Steps for invalid or inconclusive results

Every test should be performed and interpreted according to its current authorization, labeling, and instructions for use. Practices should also make sure staff understand when to repeat testing, when to confirm a result, and when to escalate care based on patient risk and clinical judgment.

The Right Test Is a Clinical and Operational Decision

The antigen-versus-molecular decision should not be reduced to speed versus accuracy. A better question is whether the test's performance, turnaround time, workflow, and intended use align with the needs of the patient in front of the clinician.

Antigen testing can provide an accessible, rapid answer that supports same-visit care. Molecular testing can provide greater sensitivity when diagnostic certainty carries additional importance. Multiplex formats in both categories can help distinguish COVID-19 from influenza A and B without relying on symptoms alone.

For primary care physicians, the strongest strategy is often a flexible one. Rapid antigen testing can be used when its speed and the clinical context make the result actionable. Molecular testing may be appropriate when patient risk, likelihood of infection, timing, or the consequences of a missed infection warrant a more sensitive approach.

For point-of-care coordinators, the task is to translate that strategy into reliable daily practice. Clear protocols, staff training, and thoughtful escalation criteria can help ensure that both antigen and molecular technologies contribute to timely, informed respiratory care without overstating what any single test can determine.

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Strep Testing: Testing Options, Accuracy, and Managing Parent Expectations

Choosing the right test—and the right patient—for a familiar clinical problem

BY ADAM IRVINE, PHYSICIANS OFFICE RESOURCE

Few office encounters appear more straightforward than a child with a sore throat. A parent reports that strep is circulating at school, the tonsils look inflamed, and the family wants an answer before leaving. Yet this common presentation requires several decisions: Is testing indicated? Which test is most appropriate? How much confidence should be placed in the result? Does a detected organism represent infection or carriage? And how can the plan be explained without making the family feel that a test or antibiotic is being withheld?

The modern physician office has more diagnostic options than ever. Traditional rapid antigen detection tests remain inexpensive and familiar. Throat culture is still an important reference method. Rapid nucleic acid amplification tests can provide molecular-level sensitivity during the visit. Each option offers advantages, but no technology eliminates the need for clinical judgment.

For physicians, the goal is not simply to find group A Streptococcus (GAS). It is to identify the patients whose symptoms are caused by GAS, treat confirmed disease appropriately, and avoid turning colonization or viral illness into an antibiotic prescription.

Testing begins with pretest probability

Viruses cause most episodes of acute pharyngitis. GAS accounts for approximately 20% to 30% of pharyngitis in children and 5% to 15% in adults. It occurs most often among children ages 5 through 15 and is uncommon in children younger than 3.1

Typical GAS features include sudden-onset sore throat, fever, painful swallowing, tender anterior cervical lymphadenopathy, palatal petechiae, tonsillar erythema, and tonsillar enlargement or exudate. Cough, rhinorrhea, hoarseness, oral ulcers, and conjunctivitis favor a viral diagnosis. When clear viral features are present, CDC guidance indicates that GAS testing is unnecessary.[1]

When viral features are absent, physical examination alone cannot reliably separate GAS from viral pharyngitis. This is where testing becomes valuable—but testing should still be selective. The 2025 Infectious Diseases Society of America (IDSA) guideline update suggests using a clinical scoring system to determine who should be tested. Centor, McIsaac, and similar tools are most useful for identifying low-probability patients in whom testing is unlikely to change care.[2]

A score is a decision aid, not a diagnosis. It should be considered alongside age, local epidemiology, household exposure, previous rheumatic fever, immune status, and signs of complicated infection. Patients with scarlet fever, a suspected deep-neck infection, or systemic toxicity require evaluation beyond a routine sore-throat pathway.

Routine testing is generally not recommended in children younger than 3 because classic GAS pharyngitis and acute rheumatic fever are rare in that age group. Selective testing may be appropriate when risk is increased, such as symptomatic illness in a young child with a school-aged sibling who has documented GAS infection.

Rapid antigen detection tests: practical, fast, and familiar

Rapid antigen detection tests (RADTs) identify GAS carbohydrate antigen from a throat swab. Most produce a result within minutes, allowing the clinician to make a treatment decision during the encounter. They are widely available, relatively inexpensive, and commonly categorized as CLIA-waived for point-of-care use.

The principal strength of RADTs is specificity. A positive result in a symptomatic, appropriately selected patient is generally considered sufficient confirmation of GAS pharyngitis. The main limitation is sensitivity, which varies among products and across clinical settings. A large systematic review in children reported an average RADT sensitivity of approximately 86% and specificity of approximately 95% when compared with throat culture.[3] Put another way, antigen testing can miss a meaningful minority of culture-positive infections even though false-positive analytic results are uncommon.

Performance is not determined by the kit alone. Organism burden, timing of illness, adequacy of the specimen, adherence to the manufacturer's instructions, and the quality of the comparator culture can all influence apparent accuracy. A rushed or superficial swab may produce a false-negative result regardless of the assay's performance in a regulatory study.

For symptomatic children age 3 or older, CDC recommends confirming a negative RADT with throat culture. The practice should have a defined system for tracking the culture, contacting the family, and prescribing an antibiotic if it becomes positive. Routine backup culture after a negative RADT is not generally recommended for adults because GAS prevalence and the risk of acute rheumatic fever are lower.[1]

Rapid molecular tests: higher sensitivity at the point of care

Nucleic acid amplification tests (NAATs) detect genetic material from GAS using methods such as polymerase chain reaction or isothermal amplification. Some platforms provide results in 15 to 30 minutes, making true molecular testing feasible during an office visit.

Rapid NAATs generally offer greater sensitivity than antigen tests. A 2021 systematic review and meta-analysis reported pooled sensitivity of 97.5% and specificity of 95.1% compared with throat culture.4 Their high negative agreement means that, for many FDA-cleared molecular assays, a negative result can be used without a backup culture. Practices must follow the instructions for the specific platform and applicable clinical guidance; "molecular" is a category, not a guarantee that every test has identical performance or follow-up requirements.

NAATs can improve workflow by reducing callbacks, delayed prescriptions, and loss to follow-up. They may be particularly valuable in high-volume pediatric, urgent care, or family medi-

cine settings where completing backup cultures is operationally difficult. Potential disadvantages include higher instrument and per-test costs, maintenance or connectivity requirements, and the need to redesign workflow around assay run time.

There is also a clinical tradeoff. High analytic sensitivity may increase detection of low-level GAS in carriers. A molecular test can establish that GAS nucleic acid is present, but it cannot independently prove that GAS is causing the sore throat. Patient selection remains essential.

Throat culture: slower, but still clinically important

Throat culture has traditionally been regarded as the diagnostic reference standard. The sample is inoculated onto appropriate media and observed for GAS growth, typically requiring 24 to 48 hours. Culture may detect infections missed by less-sensitive antigen tests and allows laboratories to characterize isolates when clinically or epidemiologically necessary.

Its weaknesses are familiar: delayed results, laboratory handling requirements, and the possibility that families cannot be reached after the visit. Culture performance also varies with specimen quality, transport, incubation, media, and laboratory technique. Although often described as a gold standard, culture is not infallible.

Culture remains especially useful as a backup after a negative antigen test in children, when a rapid molecular platform is unavailable, or when the diagnosis remains important but an immediate answer is not required. Its value depends on a closed-loop result process. A culture ordered without reliable review and family notification is not a completed diagnostic strategy.

Accuracy is more than sensitivity and specificity

Sensitivity and specificity describe test performance under defined conditions, but positive and negative predictive values change with disease prevalence. During peak GAS season in a school-aged population with compatible symptoms, a positive result is more likely to represent true disease. In a patient with cough, rhinorrhea, and a low pretest probability, the same positive result is more likely to be clinically misleading.

This is the practical consequence of indiscriminate testing: even a highly specific assay produces less useful positive results when applied to low-risk patients. The question is not only whether the test correctly detected GAS. It is whether GAS explains the illness.

Asymptomatic pharyngeal carriage makes that distinction difficult. A carrier who develops a viral upper respiratory infection may test positive by antigen, culture, or NAAT. The clinician may then attribute viral symptoms to strep and prescribe an antibiotic that offers no benefit. More sensitive testing does not remove this problem and may make it more visible.

Recurrent "strep" should prompt a review of the pattern. Were prior episodes accompanied by classic GAS features? Were tests obtained during obvious viral illnesses? Was there a clinical response consistent with the expected course? Could there be repeated exposure, incomplete adherence, or a carrier state? Routine testing of asymptomatic patients, household contacts, or patients after treatment is generally unnecessary except in selected circumstances.[5]

"The expanding menu of strep tests gives physician offices meaningful choices."

The swab is part of the test

All three diagnostic methods depend on adequate specimen collection. The swab should contact both tonsillar pillars or fossae and the posterior pharynx while avoiding the tongue, teeth, and buccal mucosa. Good lighting, proper positioning, and a deliberate technique matter.

Preparing the child can improve collection. A brief explanation—"This will touch the back of your throat, it may make you gag, and it will be over quickly"—is often better than surprising the patient. If the collector is confident that the intended anatomy was not sampled, repeating the swab may be more appropriate than accepting a questionable negative result.

Point-of-care quality systems also influence accuracy. Practices should follow storage requirements, expiration dates, control procedures, timing windows, and result-interpretation instructions. Staff need initial training and ongoing competency assessment. CLIA-waived does not mean error-proof; it means the test is simple and carries a low risk of erroneous results when performed as directed.

Matching the testing strategy to the practice

There is no single best platform for every physician office. A practice should consider its population, visit volume, staffing, laboratory certificate, follow-up reliability, available space, reimbursement environment, and total cost—not merely the purchase price of a test.

An antigen-first strategy may be appropriate when speed and affordability are priorities and the practice can reliably culture negative pediatric specimens. A molecular-first strategy may be attractive when a definitive same-visit answer is worth the added expense or when backup-culture workflows are unreliable. Culture-first testing may remain reasonable when rapid turnaround is unnecessary and laboratory access is dependable.

Before adopting a platform, clinicians should review the FDA-cleared intended use and independent performance evidence. Questions should include: What are the sensitivity and specific-

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ity in the intended age group? Is the comparator an optimized culture? Does a negative result require confirmation? What is the invalid-result rate? How long is hands-on time compared with total run time? Can the result interface with the EHR? What quality-control and maintenance procedures are required?

Practices should periodically audit their pathway. Useful measures include the percentage of sore-throat visits tested, positivity rates by age group, completion of indicated backup cultures, antibiotic prescribing after negative tests, invalid-test frequency, and time from positive culture to family notification. Unexpectedly low positivity may suggest over testing; unexpectedly high positivity can reflect appropriate selection, an outbreak, or testing of carriers and deserves context.

Managing parent expectations before the result

Parents often ask for a test because they want certainty, symptom relief, protection for siblings, or documentation for school. Addressing that concern directly is more effective than simply saying that a swab is unnecessary.

A practical conversation can follow four steps: acknowledge the concern, explain the probability, recommend a plan, and provide a safety net.

For a child with clear viral features, the clinician might say: "I understand why you're worried about strep, especially if it is going around. The cough and runny nose point strongly toward a virus. Testing now could find strep bacteria your child is carrying even if those bacteria are not causing this illness, which could lead us to use an antibiotic that will not help."

When testing is appropriate, explain the pathway before swabbing: "This rapid test is very good at confirming strep when it is positive. If it is negative, we will send a culture because rapid antigen tests can miss some infections in children. We will call you and start treatment if the culture is positive." For a molecular test, explain that the method is sensitive enough that a negative result generally ends the strep evaluation, assuming that is consistent with the specific assay's instructions.

If the result is negative, avoid presenting the encounter as a dead end. Offer a positive treatment plan: weight- and age-appropriate analgesics or antipyretics, hydration, soothing liquids, and other appropriate comfort measures. Explain the expected course and provide clear reasons to return, including breathing difficulty, drooling or inability to swallow, dehydration, neck swelling or stiffness, trismus, muffled voice, toxic appearance, new rash, persistent fever, or worsening symptoms.

When a parent expects antibiotics, concise language can preserve trust: "The negative result tells us that an antibiotic is unlikely to help. Antibiotics can cause diarrhea, rash, allergic reactions, and other problems, so the safest treatment is symptom relief and close observation. If the culture changes the answer, we will contact you."

For confirmed GAS, set realistic expectations. Antibiotics shorten illness modestly, reduce transmission, and lower the risk of complications; they do not necessarily produce immediate relief. Penicillin or amoxicillin remains first-line therapy for patients without an allergy. Patients should be afebrile and have received appropriate antibiotics for at least 12 to 24 hours before returning to school or daycare, consistent with CDC guidance.[1]

Better technology, better conversations

The expanding menu of strep tests gives physician offices meaningful choices. RADTs provide rapid, specific, affordable results but can miss infections. NAATs offer higher sensitivity and often eliminate backup culture, though at greater cost and with continued risk of detecting carriage. Culture remains valuable but requires time and a dependable follow-up system.

The best test is therefore not simply the assay with the highest sensitivity. It is the test that fits the patient's pretest probability, the practice's workflow, and a clear management plan. Used selectively, collected correctly, and interpreted in context, strep testing can support both diagnostic accuracy and antibiotic stewardship.

Parents are more likely to accept that approach when clinicians explain not only what they are doing, but why. A well-managed encounter leaves the family with an answer when possible, a plan in every case, and confidence that avoiding an unnecessary test or antibiotic is an act of careful medicine—not inaction.

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This product has been authorized only for the detection of proteins from SARS-CoV-2, influenza A and influenza B, not for any other viruses or pathogens; and, in the USA, the emergency use of this product is only authorized for the duration of the declaration that circumstances exist justifying the authorization of emergency use of in vitro diagnostics for detection and/or diagnosis of COVID 19 under Section 564(b)(1) of the Federal Food, Drug and Cosmetic Act, 21 U.S.C. §360bbb-3(b)(1), unless the declaration is terminated or authorization is revoked sooner.

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Status Flu A & B is an in vitro rapid qualitative test that detects influenza type A and type B directly from nasal swab, nasopharyngeal swab, and nasopharyngeal aspirate/wash specimens obtained from patients with signs and symptoms of respiratory infection. It is intended to aid in the rapid differential diagnosis of Influenza A and B viral infections.

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How Point-of-Care Testing Impacts Parental Satisfaction

BY MATT BAKER, PHYSICIANS OFFICE RESOURCE

Rapid results can reduce uncertainty, support shared decision-making, and create a more complete pediatric visit—but only when point-of-care testing is clinically appropriate, accurately performed, and paired with clear communication.

A parent enters the physician's office carrying more than a sick child. The parent may also bring several nights of interrupted sleep, concerns about a persistent fever, pressure from a school or childcare center, and the practical need to know whether the child can return to normal activities. Above all, the parent wants an answer: Will my child be ok, what is wrong, and what should we do next?

Point-of-care testing (POCT) can help clinicians answer those questions before the family leaves the office. Whether testing for group A streptococcal pharyngitis, influenza, SARS-CoV-2, respiratory syncytial virus, urinary tract infection, glucose abnormalities, or other conditions, near-patient testing can compress the diagnostic timeline from days to minutes.

That speed can improve the parent's experience. However, rapid testing does not automatically produce greater satisfaction. The effect depends on how the test is selected, performed, interpreted, and communicated. Used well, POCT can strengthen parental confidence and support more efficient, family-centered care. Used indiscriminately, it can create confusion, false reassurance, unnecessary treatment, and dissatisfaction.

Parents Are Often Seeking Certainty, Not a Prescription

When parents bring an acutely ill child to a physician's office, the apparent request may be for a test, an antibiotic, or another specific intervention. The underlying need is frequently reassurance.

A qualitative study examining parent and clinician perspectives on diagnostic testing for pediatric diarrhea found that reassurance was a primary reason parents sought care. Some parents worried that without diagnostic testing, clinicians were merely speculating about the cause of the illness and might not be selecting the most appropriate treatment.[1] These findings illustrate the symbolic importance of testing: To many parents, a test represents thoroughness, objectivity, and clinical certainty.

Nevertheless, testing is not the only—or necessarily the best—way to provide reassurance. In one pediatric emergency department study, 28.4% of parents expected a laboratory test, while 31.3% expected an antibiotic. Yet simply making clinicians aware of parents' written expectations did not improve satisfaction. Sensitivity to parental fears and concerns received particularly high satisfaction ratings, reinforcing that communication and empathy remain fundamental components of the experience.[2]

POCT can support reassurance because it provides information while the clinical conversation is still taking place. Instead of telling a parent that results will be available later, the clinician may be able to review the answer, explain its meaning, and establish a care plan during the same visit. The family leaves with fewer unresolved questions and a clearer understanding of what to expect.

The important distinction is that the test does not replace the physician's explanation. It gives that explanation a timely clinical anchor.

Rapid Results Can Make the Visit Feel More Complete

A traditional send-out test often divides a pediatric encounter into multiple disconnected steps: specimen collection, laboratory transport, result review, a telephone call or portal message, and perhaps a new prescription. Each transition creates another opportunity for delay, missed communication, or parental uncertainty.

POCT can bring those steps together. When results are available before discharge, the clinician can explain the diagnosis, treatment recommendation, return precautions, and expected course in one continuous interaction. Parents can ask questions while the physician is present rather than trying to interpret a result through a portal notification later that evening.

This sense of closure is especially valuable when the result changes immediate management. A positive group A streptococcal test may support antibiotic treatment, while a negative result may facilitate a discussion about viral illness and symptomatic care. A positive influenza result may affect antiviral decisions in an appropriate patient. A urine dipstick may determine whether empiric treatment, culture, or additional evaluation is warranted.

Clinical studies have demonstrated that pediatric POCT can influence both resource use and patient flow. Following the introduction of rapid molecular influenza testing in one pediatric emergency department, investigators observed reductions in blood counts, blood cultures, urine testing, and chest radiographs, along with a modest reduction in median length of stay.[3] Although such operational findings do not directly prove improved parental satisfaction, fewer invasive procedures and a faster, more decisive encounter are likely to improve several aspects of the family experience.

The relationship between time and satisfaction, however, is not entirely straightforward. Research in pediatric emergency settings suggests that satisfaction is influenced not only by actual waiting time but also by parents' perceptions of that time, the quality of staff communication, pain management, and how well clinicians work together.[4] In other words, a rapid result may help, but a five-minute test followed by 30 minutes of unexplained waiting may still feel slow.
Practices should therefore consider the entire result-to-decision interval—not simply the analytical turnaround time printed on the package insert.

POCT Can Strengthen Shared Decision-Making

When performed during the visit, testing can become part of a visible and collaborative decision-making process. The

physician can explain why a particular test is appropriate, what question it is intended to answer, and how each possible result would affect the plan.

This approach is particularly useful when parents expect antibiotics. A negative result can provide tangible support for a recommendation to avoid unnecessary treatment, but the result must be placed in context. The physician might say:

"Today's findings and the test result both point away from a bacterial infection. That means an antibiotic is unlikely to help and could cause side effects. Let's talk about what will help, how long the symptoms may last, and what changes should prompt you to call us."

That explanation does more than deny a requested prescription. It replaces the prescription with a diagnosis-oriented plan.

POCT may also increase parents' perception that the physician has listened carefully and taken the concern seriously. Recent qualitative research involving caregivers of young children with respiratory symptoms found that families assigned meanings to POCT that extended beyond the biological result. Testing shaped how caregivers interpreted the consultation, the clinician's actions, and the seriousness with which the child's illness was treated. The study also emphasized that the meaning of a test develops through communication between the caregiver and clinician.[5]

For practices, the lesson is clear: Explain the purpose of testing before collecting the specimen. Without that explanation, parents may assume that the test is more comprehensive or conclusive than it actually is.

Accuracy Is Part of the Patient Experience

Parents generally experience a rapid test as an answer. Clinicians must recognize it as one piece of diagnostic evidence.

Every POCT method has limitations related to sensitivity, specificity, specimen quality, timing, disease prevalence, and patient selection. A result that is inconsistent with the clinical presentation may require confirmation or an alternative diagnostic approach. These limitations are not merely laboratory concerns; they directly affect parental trust.

Group A streptococcal testing provides a familiar example. Rapid antigen detection tests have high specificity but variable sensitivity compared with throat culture. Current CDC guidance recommends obtaining a backup throat culture after a negative rapid antigen test in symptomatic children older than 3 years. The practice must also have a reliable mechanism for contacting the family and initiating treatment when the backup culture is positive.[6]

If parents are told only that the "rapid strep test was negative," they may reasonably interpret the answer as final. If a culture later returns positive, the change can appear to be an error or reversal. Satisfaction is better protected when expectations are established at the initial visit:

For practices, the lesson is clear: Explain the purpose of testing before collecting the specimen. Without that explanation, parents may assume that the test is more comprehensive or conclusive than it actually is.

"The rapid test is negative, which is reassuring, but in children we confirm that result with a culture because the rapid method can occasionally miss an infection. We will contact you if the culture changes the plan."

Similar care is needed with respiratory testing. A negative antigen test may not exclude infection when clinical suspicion is high, while a positive molecular result may identify viral material that must still be interpreted in the context of symptoms and timing. Multiplex panels can provide several answers at once, but they can also generate incidental or difficult-to-interpret findings.

The most satisfying answer is not necessarily the fastest one. It is the answer the family can understand and trust.

The Specimen-Collection Experience Matters

From the parent's perspective, POCT includes everything that happens between the decision to test and the explanation of the result. A test may be analytically excellent while still producing a poor experience if specimen collection is painful, frightening, or repeatedly unsuccessful.

Throat and nasal swabs can be distressing for young children. Fingersticks can provoke anxiety. Urine collection in infants can prolong the visit or require invasive catheterization. Child-friendly preparation can substantially change how the procedure is perceived.

Before collection, staff should tell the child and parent what will happen in developmentally appropriate language. Whenever feasible, parents should be given a constructive role, such as positioning or comforting the child. Distraction, comfort holds, and confident technique can reduce distress. Teams should also avoid promising that a procedure "won't hurt" or "will be over instantly." Honest, calm explanations preserve credibility.



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The operational goal should be obtaining a valid specimen on the first attempt. Poor technique creates both an emotional cost and an accuracy problem. Inadequate throat swabbing, improperly timed readings, incorrect sample volumes, and failure to follow storage requirements can produce unreliable results.

Building a Parent-Centered POCT Workflow

Practices seeking to use POCT as both a clinical and patient-experience tool should focus on five principles.

First, test only when the result can answer a defined clinical question or meaningfully influence management. "What will I do differently if this test is positive or negative?" remains a useful checkpoint.

Second, set expectations before collecting the specimen. Tell parents what is being tested, how long the result usually takes, what the test cannot determine, and whether confirmatory testing may be needed.

Third, design the workflow around the full turnaround time. Assign responsibility for starting the test, monitoring it, documenting the result, notifying the clinician, and returning to the examination room. A rapid platform provides little experiential advantage if results sit unnoticed.

Fourth, standardize quality practices. CLIA requirements apply to U.S. facilities performing testing on human specimens, including applicable waived testing. CMS describes the goal of CLIA as ensuring that laboratory results are accurate, reliable, and timely.[7] Practices should follow manufacturer instructions, maintain quality-control and maintenance records, train personnel, verify kit storage conditions, and periodically observe testing technique.

Finally, close the communication loop. Every result should be accompanied by an interpretation and plan—not simply "positive" or "negative." Explain what the result means, what treatment is recommended, when the child can return to school or childcare, what symptoms are expected, and when the family should seek additional care.

Measuring What Parents Actually Value

Practices should not assume that installing a faster testing platform will automatically improve satisfaction scores. The effect should be measured.

Useful metrics include specimen-to-result time, total visit duration, repeat specimen rate, follow-up call volume, antibiotic prescribing, confirmatory testing, result-notification failures, and parent-reported understanding of the plan. A short post-visit question—"Did you leave knowing what the test result meant and what to do next?"—may be more actionable than a general satisfaction score.

It is also helpful to review negative comments for patterns. Parents may not complain that a test took 15 minutes; they may say that no one told them why they were waiting. They may not object to a negative result; they may object that no alternative explanation or symptom-management plan was provided.

These distinctions allow the practice to improve the workflow rather than simply purchase a faster analyzer.

The Value of an Answer Before the Family Leaves

Point-of-care testing can improve parental satisfaction by reducing uncertainty, shortening the path to a decision, limiting unnecessary procedures, and allowing families to participate in a real-time discussion of the diagnosis. It can transform an open-ended visit into a more complete clinical encounter.

Its greatest value, however, is not speed alone. Parents want to know that their concerns were heard, their child was carefully evaluated, and the treatment plan is based on sound reasoning. POCT supports those goals when it is appropriately selected, accurately performed, and thoughtfully explained.

The most successful practices do not present rapid testing as a substitute for clinical judgment. They use it to make clinical judgment more visible. When the result, the physician's assessment, and the family's questions are brought together before the visit ends, parents leave with something more valuable than a laboratory answer: They leave with confidence in what comes next.

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This test has not been FDA cleared or approved. It is authorized by FDA under an EUA for use by authorized laboratories. It has been authorized only for the detection of proteins from SARS-CoV-2, influenza A and influenza B, not for any other viruses or pathogens and is only authorized for the duration of the declaration that circumstances exist justifying the authorization of emergency use of in vitro diagnostics for detection and/or diagnosis of COVID-19 under Section 564(b)(1) of the Federal Food, Drug, and Cosmetic Act, 21 U.S.C S360bbb-3(b)(1), unless the authorization is terminated or revoked sooner.



FLU AND RESPIRATORY

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510(k) cleared for confidence, a simple workflow, and fast results make it an ideal choice for physician offices, urgent care centers, clinics, and home use.



GASTROINTESTINAL DISEASE TESTING

PARA-PAK® STOOL TRANSPORT VIALS

From Meridian Bioscience

6727

SCAN TO LEARN MORE

Para-Pak® Stool Transport Vials help physician practices simplify stool specimen collection by providing patients with an easy-to-use at-home collection and transport solution. Designed to preserve specimen integrity during transport to the laboratory, Para-Pak is available with trusted transport media to support a variety of diagnostic testing needs. User-friendly collection devices help simplify specimen collection while promoting efficient workflows and reliable diagnostic testing.



LEAD TESTING

MEET LEADCARE® II

From Meridian Bioscience

6728

SCAN TO LEARN MORE

LeadCare® II brings CLIA-waived blood lead testing directly to the point-of-care — so you can test, educate, and take action in a single visit. For pediatric practices, every well-child visit is an opportunity to protect a child's development. With rapid, quantitative results in just three minutes from a simple fingerstick, you can counsel families and initiate next steps immediately — turning screening into meaningful action when it matters most.



PERIPHERAL ARTERIAL DISEASE

QUANTAFLO® PAD

From Semler Scientific

6729

SCAN TO LEARN MORE

QuantaFlo® PAD is an easy to use, accurate, point of care, non-invasive solution that aids in the early detection of peripheral arterial disease (PAD). This FDA cleared device can be administered by a medical aide in less than 5 minutes. As published in the Journal of Vascular Surgery and the American Journal of Preventive Medicine, QuantaFlo detected undiagnosed PAD in 31.6% of patients +65.1 QuantaFlo is portable and integrates with other technologies and platforms. It is ideal for both home and clinic environments.

1. Smolderen KG, Ameli O, Chaisson CE, Heath K, Mena-Hurtado C. Peripheral Artery Disease Screening in the Community and 1-Year Mortality, Cardiovascular Events, and Adverse Limb Events, AJPM Focus (2022), https://doi.org/10.1016/j.focus.2022.100016



PAD TESTING SYSTEMS IDEAL FOR PRIMARY CARE TO VASCULAR SPECIALISTS

from Newman Medical

6730

SCAN TO LEARN MORE

Your Patients Trust YOU To Find Their Peripheral Artery Disease
- High-risk patients include those over 65, diabetics, and smokers.
- If left untreated, 25% of patients with PAD will experience a heart attack or stroke within 5 years.
- PAD symptoms are often mistaken for arthritis or old age.

The simpleABI Cuff-Link System is Easy to Learn and Use.
- With a push-button remote, automatic calculations, and waveforms, it's incredibly user-friendly.
- Reports are straightforward to save and share since the system is PC-based.

Outstanding Value and Reimbursements
- The system pays for itself in less than a year with just one test per week.
- Medicare reimbursements vary by exam and location, averaging from $91 to $174.



BD Veritor™ Plus System

Your simple solution



Digital clarity:

- Unambiguous positive/negative display which may help to reduce result interpretation errors and streamline diagnosis.

Easy to use:

- No monthly calibration required, operated with single-button functionality.

Cost-effective:

- No service contracts, maintenance or calibration needed for device lifetime.

Rapid results:

- Delivers digitally read results in 15 minutes or less,** supporting timely clinical decisions.

Flexible workflow options:

- Walk Away mode: Built in timer allows you to perform other tasks throughout test development.
- Analyze Now mode: Enables immediate processing to support batch testing.†
- Compact, lightweight and portable—able to function without cords.

Learn more at
bdveritor.com

*In the USA, the BD Veritor™ System for Rapid Detection of SARS-CoV-2 & Flu A+B has not been FDA cleared or approved but has been authorized by the FDA under an Emergency Use Authorization for use by authorized laboratories; use by laboratories certified under the CLIA, 42 U.S.C. §263a, that meet requirements to perform moderate, high, or waived complexity tests. The product is authorized for use at the Point of Care (POC), i.e., in patient care settings operating under a CLIA Certificate of Waiver, Certificate of Compliance, or Certificate of Accreditation. This product has been authorized only for the detection of proteins from SARS-CoV-2, influenza A and influenza B, not for any other viruses or pathogens; and, in the USA, the emergency use of this product is only authorized for the duration of the declaration that circumstances exist justifying the authorization of emergency use of in vitro diagnostics for detection and/or diagnosis of COVID 19 under Section 564(b)(1) of the Federal Food, Drug and Cosmetic Act, 21 U.S.C. §360bbb-3(b)(1), unless the declaration is terminated or authorization is revoked sooner.
**Result processing times for each BD Veritor™ assay are 15 minutes for the SARS-CoV-2 and SARS-CoV-2 & Flu A+B assays, 10 minutes for Flu A+B and RSV assays, and 5 minutes for the Group A Strep assay.
†Any batch testing performed should be conducted at the discretion of the user, in accordance with local policies and clinical judgment.

BD, Sparks, MD, 21152, U.S. • 201.847.6800

bd.com

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(BD-166704 4515-US-1225 December 2025)

STREP TESTS

BD VERITOR™ SYSTEM FOR RAPID DETECTION OF SARS-COV-2 & FLU A+B* (EUA) TEST

From BD Veritor™ Plus System

6732

SCAN TO LEARN MORE

A 3-in-1 antigen assay for COVID-19, Flu A and Flu B with test results in 15 minutes.[1]

The BD Veritor™ Plus System streamlines clinical and patient workflows by detecting three key respiratory viruses in one test, reducing the need for multiple sample collections. With multiple testing modes and workflow efficiencies, the analyzer empowers convenience and efficiency (1 kit = 30 tests).



*In the USA, the BD Veritor™ System for Rapid Detection of SARS-CoV-2 & Flu A+B has not been FDA cleared or approved but has been authorized by the FDA under an Emergency Use Authorization for use by authorized laboratories; use by laboratories certified under the CLIA, 42 U.S.C. §263a, that meet requirements to perform moderate, high, or waived complexity tests. The product is authorized for use at the Point of Care (POC), i.e., in patient care settings operating under a CLIA Certificate of Waiver, Certificate of Compliance, or Certificate of Accreditation.

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1. BD Veritor™ Plus System for Rapid Detection of SARS-CoV-2 and Flu A+B. Package insert. 500051910 Becton, Dickinson and Company.

OSOM® ULTRA STREP A TEST

From Sekisui Diagnostics

6733

SCAN TO LEARN MORE

The OSOM® Ultra Strep A test is a color immunochromatographic assay intended for the qualitative detection of Group A Streptococcus antigen directly from throat swab specimens. Shown to be not statistically different than single swab culture. Sensitivity 95.7% and 100% Specificity. Includes two additional test sticks for External QC. CLIA Waived.



ULTRASOUND

ETHOS AUTOMATED ULTRASOUND PROBE CLEANER DISINFECTOR

From CS Medical

6734

SCAN TO LEARN MORE

The Ethos Automated Ultrasound Probe Cleaner Disinfector is the first FDA-cleared device to provide both cleaning and high-level disinfection of ultrasound probes in one system. It's fast and easy to use—simply place a soiled transvaginal, transrectal, or surface probe into the device, follow the prompts on the display, and a reprocessing report is printed at the end of the cycle. Ethos removes the unknowns of manual cleaning, giving healthcare professionals confidence and consistency with every cycle.



WOMEN'S HEALTH

OSOM® BVBLUE®

From Sekisui Diagnostics

6735

SCAN TO LEARN MORE

The OSOM® BVBLUE® detects elevated vaginal fluid sialidase activity, an enzyme produced by bacterial pathogens associated with bacterial vaginosis including Gardnerella, Bacteroides, Prevotella and Mobiluncus. OSOM® BVBLUE® is more sensitive than Amsel criteria providing physicians with a more accurate diagnosis to treat and minimize serious health consequences such as early spontaneous preterm births and miscarriage.



OSOM® TRICHOMONAS RAPID TEST

From Sekisui Diagnostics

6736

SCAN TO LEARN MORE

The OSOM® Trichomonas Rapid Test is intended for the qualitative detection of Trichomonas vaginalis antigens from vaginal swabs or from the saline solution. The OSOM® Trichomonas Rapid Test is a CLIA-waived rapid test available today. OSOM® Trichomonas is more sensitive than wet mount due to the assay being able to detect viable and non-viable organisms which offers significant benefits to the patient and clinician alike.



ULTRA HCG COMBO TEST

From Sekisui Diagnostics

6737

SCAN TO LEARN MORE

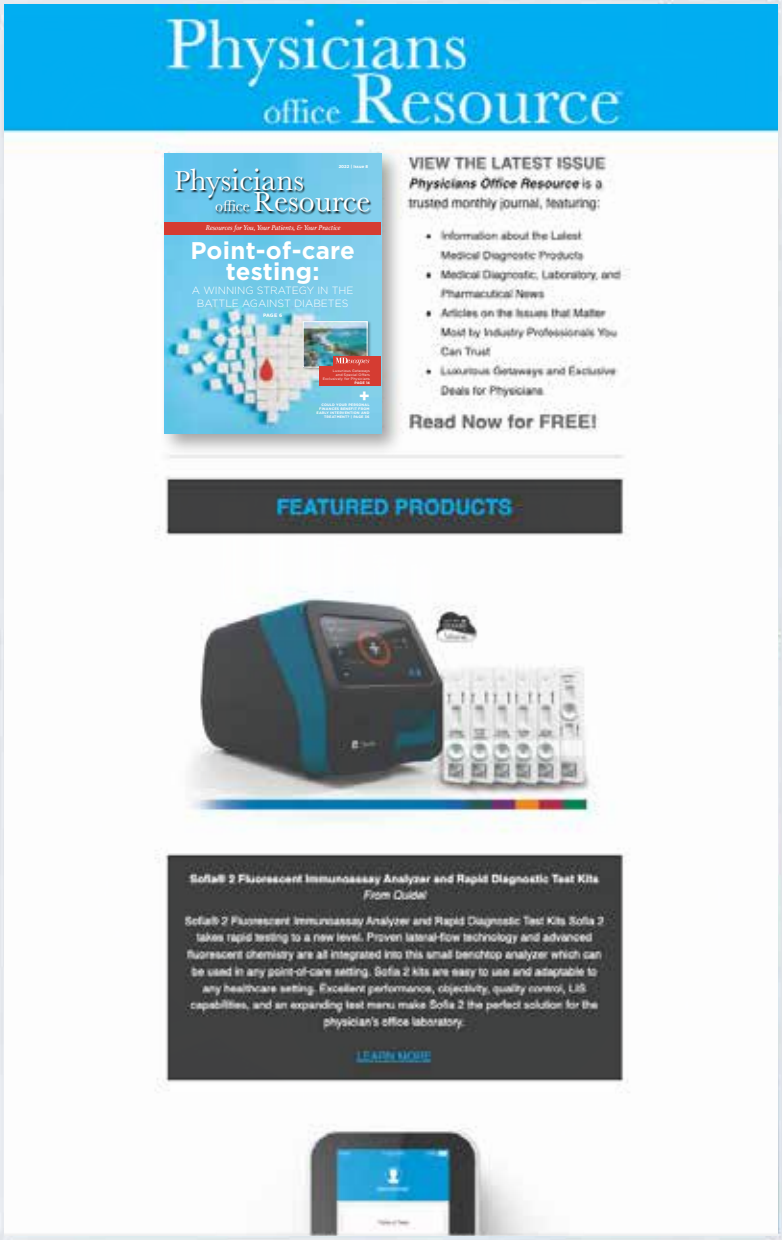
The OSOM® Ultra hCG Combo test is a simple immunoassay for the qualitative detection of human chorionic gonadotropin (hCG) in serum or urine for the early confirmation of pregnancy. Internal studies have confirmed that the OSOM® Ultra hCG Combo test does not have a false negative result from hCG variants providing physicians with a higher level of confidence.



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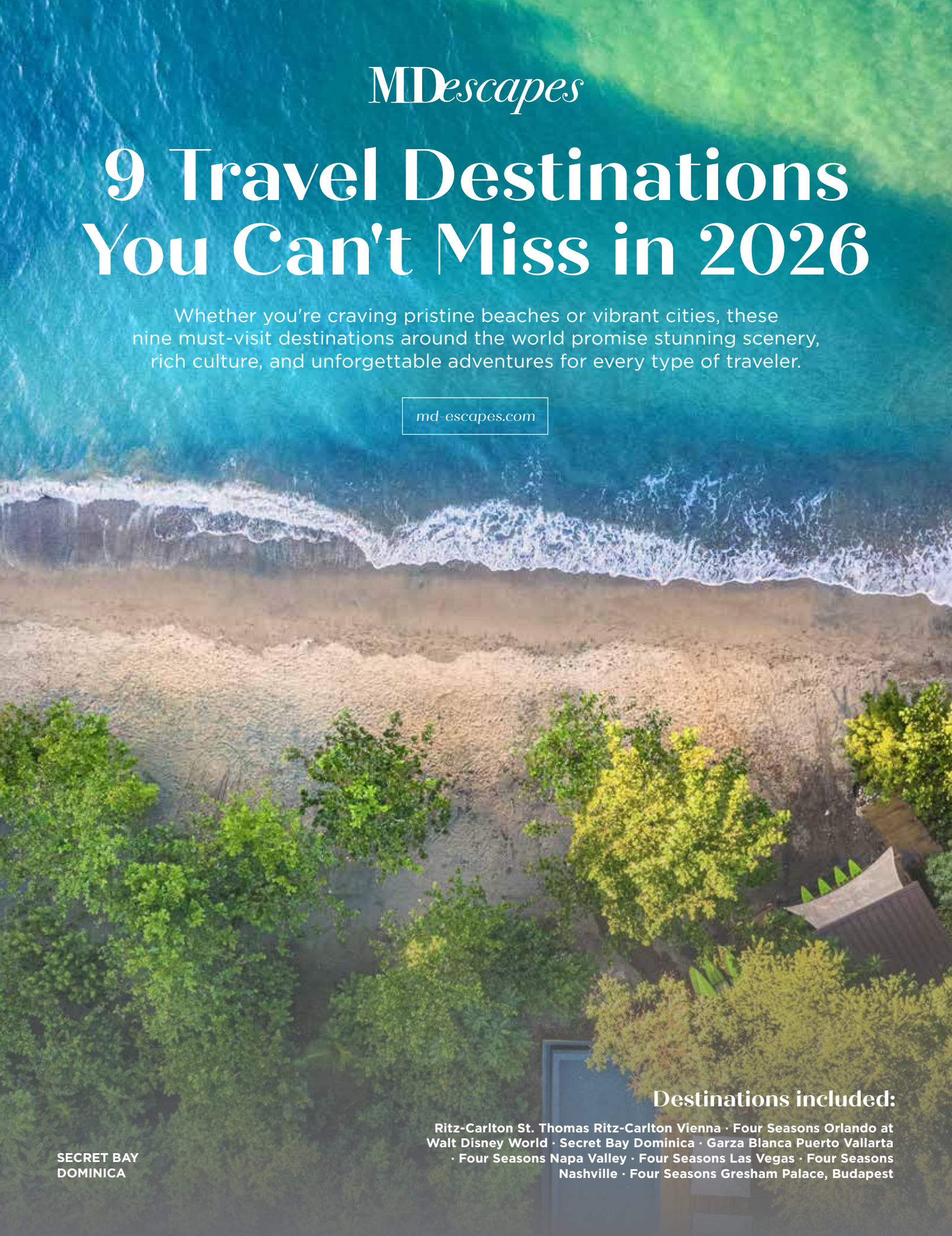
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MDescapes

9 Travel Destinations You Can't Miss in 2026

Whether you're craving pristine beaches or vibrant cities, these nine must-visit destinations around the world promise stunning scenery, rich culture, and unforgettable adventures for every type of traveler.

md-escapes.com



SECRET BAY
DOMINICA

Destinations included:

Ritz-Carlton St. Thomas Ritz-Carlton Vienna · Four Seasons Orlando at Walt Disney World · Secret Bay Dominica · Garza Blanca Puerto Vallarta · Four Seasons Napa Valley · Four Seasons Las Vegas · Four Seasons Nashville · Four Seasons Gresham Palace, Budapest

MDescapes

RITZ-CARLTON
ST. THOMAS

Escape to an island oasis surrounded by crystal blue waters, white sand and lush tropical greenery. A breathtaking 30 acre, oceanfront luxury hotel in St. Thomas, VI, The Ritz-Carlton, St. Thomas is a Caribbean marvel styled after traditional island architecture, but richly updated with all of the contemporary comforts for which the resorts of The Ritz-Carlton are known.

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RITZ-CARLTON ST. THOMAS



THE RITZ-CARLTON VIENNA

THE RITZ-CARLTON
VIENNA

In a city renowned for its beauty and culture, The Ritz-Carlton, Vienna distinguishes itself with a unique blend of modern luxuries, fine dining, and spa experiences, all housed within four 19th-century palaces. Situated in the heart of downtown Vienna, along the iconic Ringstrasse and adjacent to the Stadtpark, our luxury hotel offers 200 elegant guestrooms, including 43 exquisite suites, allowing you to indulge in tasteful living, distinctive designs, and breathtaking views.

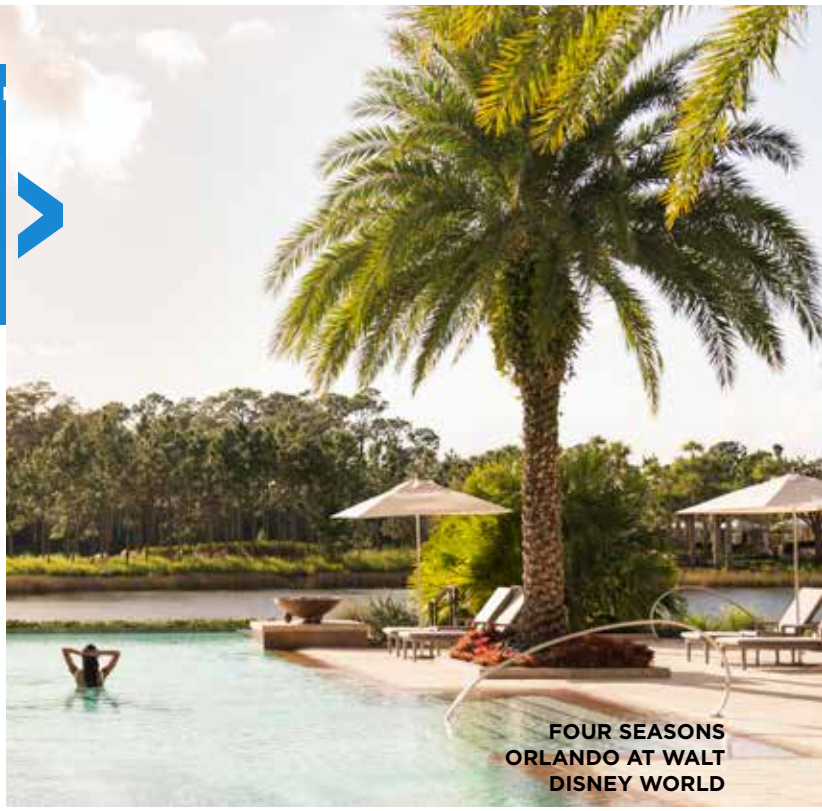
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FOUR SEASON ORLANDO AT WALT DISNEY WORLD

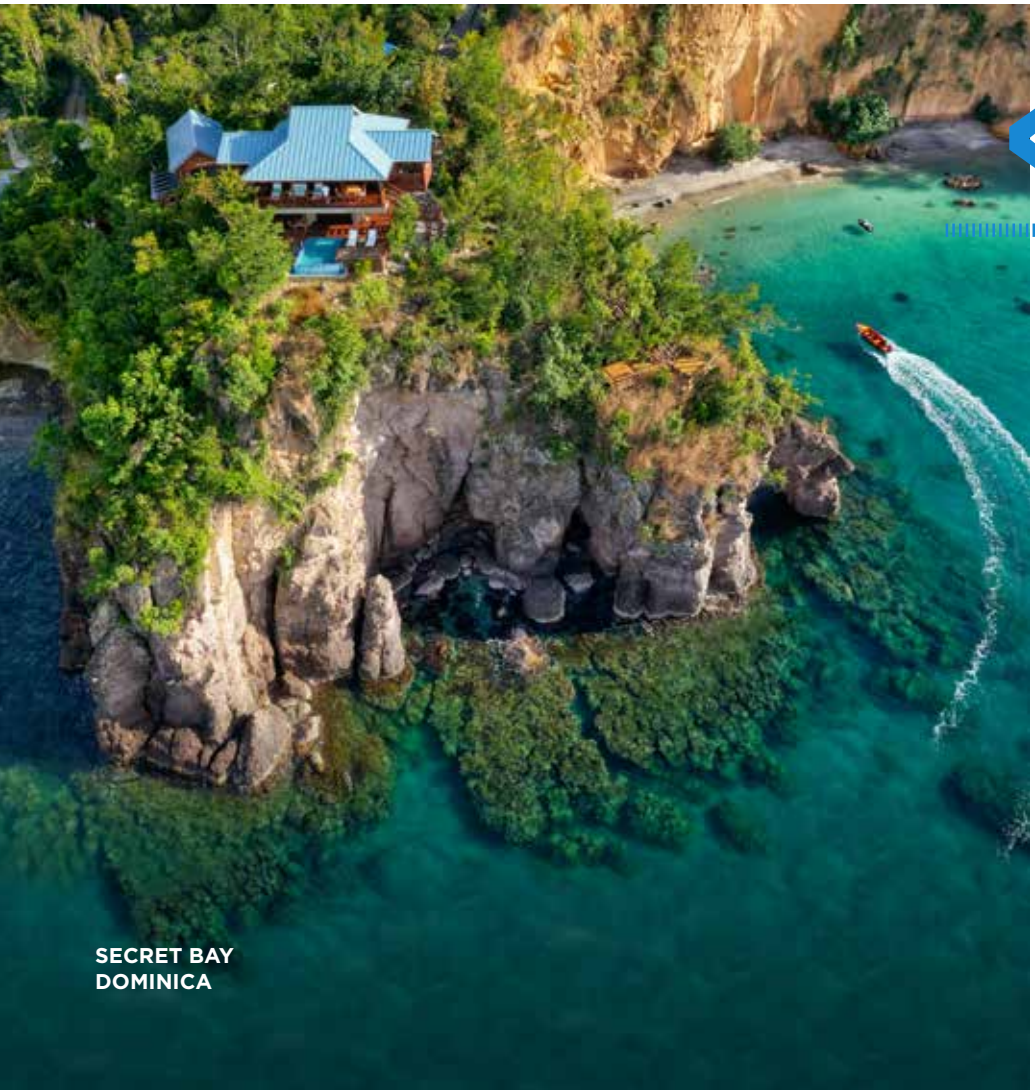
ORLANDO, FLORIDA

Discover an elevated escape with the perfect balance of fun and relaxation at our AAA Five Diamond, luxury Orlando Resort. Splash around with the family at Explorer Island water park, or unwind beneath swaying palms at Oasis adult-only pool while we entertain your young ones at our complimentary kids camp. Treat yourself to a soothing, post-park massage at The Spa, then toast to the nightly Walt Disney World® fireworks views over dinner at our Michelin-starred rooftop steakhouse Capa.

SCAN TO LEARN MORE



FOUR SEASONS ORLANDO AT WALT DISNEY WORLD



SECRET BAY DOMINICA

SECRET BAY

DOMINICA

Spectacularly sited on a clifftop promontory where the rainforest meets the sea on Dominica, the "Nature Island" of the Caribbean, Secret Bay is among the leading boutique resorts in the world and an acclaimed Relais & Châteaux property. The secluded six-star, all-villa resort consists of elegantly appointed, residential-style villas, each with a private plunge pool and dedicated villa host, on-call concierge, chefs and guides, access to a secret beach and transformative experiences curated specifically for each guest.

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MDescapes

GARZA BLANCA
PUERTO VALLARTA

All Inclusive Family Resort in Puerto Vallarta. Experience the best all-inclusive resort in Puerto Vallarta, where first-class amenities invite you to relax by infinity pools, indulge in gourmet dining, and rejuvenate at a world-class spa embraced by jungle and ocean views. Garza Blanca Puerto Vallarta combines breathtaking natural beauty, exceptional service, and upscale comfort for an unforgettable luxury family vacation.

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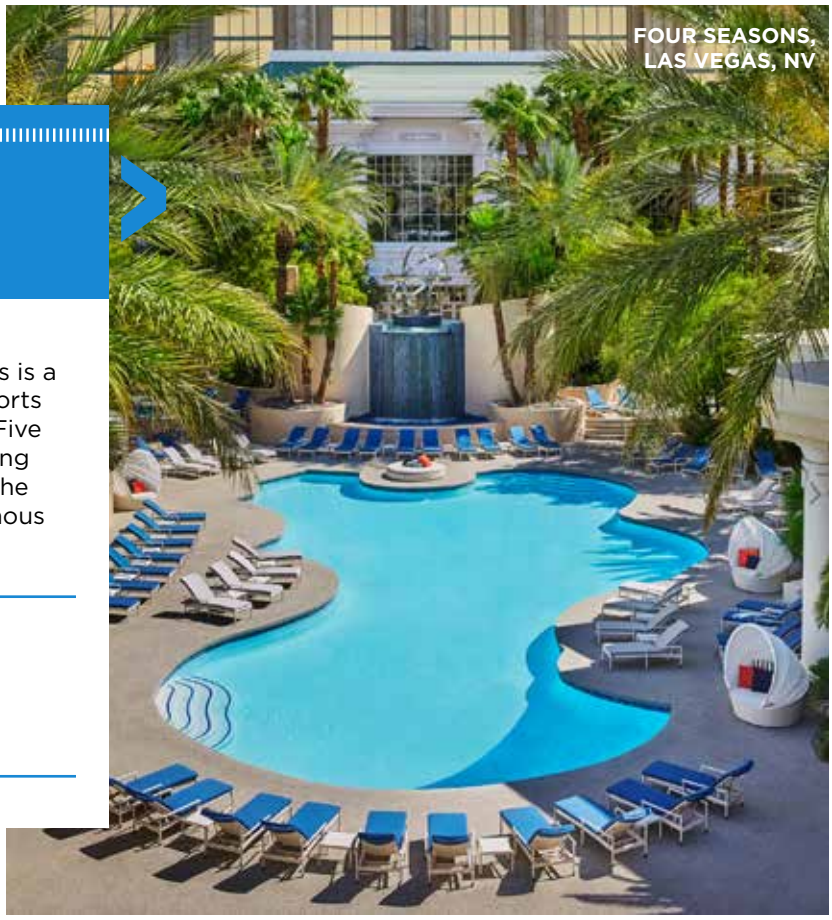

GARZA BLANCA
PUERTO VALLARTA


FOUR SEASONS
NAPA VALLEY

FOUR SEASONS
NAPA VALLEY

Welcome to Five-Star Luxury in California Wine Country. In the food and wine capital of North America, Four Seasons welcomes you to a bespoke luxury resort in Napa Valley, the heart of California wine country. Our Forbes Five-Star Hotel in Calistoga is set within its own world-class vineyard. Discover innovative and seasonal cuisine at Michelin-starred Auro, holistic spa rituals at Spa Talisa and thoughtfully personalized Four Seasons service. Raise a glass to all the best in life as you soak in magnificent views of Napa Valley.

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FOUR SEASONS, LAS VEGAS, NV

FOUR SEASONS
LAS VEGAS, NEVADA

As one of the only non-gaming and non-smoking hotels on The Strip, Four Seasons Hotel Las Vegas is a unique oasis in the heart of the action-packed sports and entertainment capital of the world. Offering Five Diamond luxury accommodations, acclaimed dining and a Forbes Five-Star spa, Four Seasons offers the best of both worlds: a resort retreat amid the famous energy of Las Vegas.

SCAN TO LEARN MORE



FOUR SEASONS NASHVILLE

FOUR SEASONS
NASHVILLE, TENNESSEE

Welcome to Four Seasons Hotel Nashville, a luxury hotel located in the heart of downtown's vibrant SoBro neighborhood. This new social hub is just steps away from the city's iconic music, sports, and entertainment venues. Experience the rhythm of our lively restaurants and event spaces, the tranquility of our Spa, and the stunning views from our rooftop pool overlooking the Cumberland River and Riverfront Park. With the unmatched service of Four Seasons and warm Southern hospitality, we'll inspire an authentic experience of Music City.

SCAN TO LEARN MORE



FOUR SEASONS GRESHAM PALACE
BUDAPEST

Located in the heart of Budapest, our luxury art nouveau palace Hotel – the only Forbes Five-Star hotel in Hungary – embodies the spirit of Budapest's Golden Era glam. From the moment you enter the iconic wrought iron peacock gates, pass through the lobby adorned with more than two million mosaic tiles illuminated with its striking chandelier, and let inspiration wash over you. Outside, views of the Danube and the picturesque Buda skyline stand before you. Spend the day exploring the sights, recharge in our Spa that harnesses the city's heritage in wellness, then enjoy an innovative cocktail at our lobby bar MÚZSA.

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Early Detection,

Rapid Diagnosis,

Better Outcomes



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To learn more about our full line of Rapid Diagnostic tests vist our website at **www.lifesignmed.com** to learn more about our products

statID PRO™
COVID-19/Flu A&B



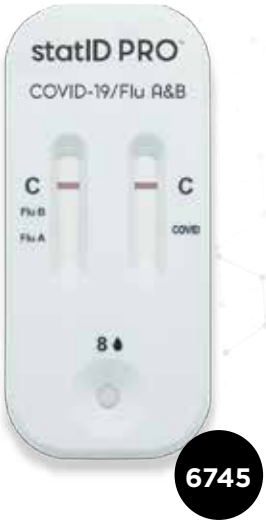
Is it COVID or Flu?
Know in 15 Minutes.

One swab. Three answers. Faster decisions at the point of care.

When symptoms overlap, fast and accurate differentiation matters. StatID PRO™ helps you triage patients efficiently, improve patient flow, and deliver care when it matters most.

StatID PRO™ Features:

- Clear, visual results to support confident decision-making
- CLIA-waived and FDA-cleared for use in physician offices and urgent care settings
- Support timely antiviral decisions during peak respiratory season
- Reduce unnecessary follow-up testing and visits
- Easy-to-use workflow with minimal hands-on time



6745

Scan the QR code to learn more or order today!

meridian BIOSCIENCE®