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## President's Message, Nov. 2017

**U.S. Antibiotic Awareness Week - November 13-19, 2017**
*By Bobby Redwood, MD, MPH*

Greeting Wisconsin Emergency Physicians! As we boldly stride forth into cold and flu season (or perhaps we're getting dragged, kicking and screaming), I would like to take a moment to celebrate one of the lesser-known Fall holidays: U.S. Antibiotic Awareness Week is November 13-19, 2017!

To celebrate the occasion, academic and community emergency physicians from across the state have compiled two top 10 lists to help guide emergency physicians' clinical practice. These evidence-based recommendations have been compiled by the Department of Health Services Antimicrobial Stewardship Emergency Medicine Sub-Committee and will be available in print form next month.

Here's an online preview; feel free to print out the PDFs (which include references) and post in your ED!

**Top Ten Ways for Emergency Physicians to Avoid Prescribing Unnecessary Antibiotics (download)**

**1. Beware UTI myths. 40% of antibiotics given in hospital settings are avoidable.** Odor, bacteriuria, nitrates, leukocyte esterase, and pyuria cannot diagnose UTI without clinical signs/symptoms.

**2. Use the modified Centor Score for pharyngitis.** One point is assigned for each of the following criteria: fever, absence of cough, tonsillar exudates, and swollen/tender anterior cervical nodes. Current guidelines recommend no rapid testing and withholding antibiotics in patients with scores of zero and one, and treating only positive rapid test results for scores of two or greater.

**3. Treat sinusitis as viral unless strict criteria are met.** Sinusitis symptoms must be present for ≥10 days without any evidence of clinical improvement OR patient has severe symptoms or signs of high fever (≥39°C [102°F]) and purulent nasal discharge or facial


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pain lasting for at least 3–4 consecutive days OR worsening symptoms or signs characterized by the new onset of fever, headache, or increase in nasal discharge following a typical viral upper respiratory infection. If criteria are met, first-line therapy should be a 10-day course of amoxicillin.

**4. Avoid screening for asymptomatic bacteriuria.** Asymptomatic bacteriuria is common, It is present in up to 5% healthy premenopausal women, 22% community dwelling elder women, 50% and 35% of institutionalized women and men respectively. Urinalysis for infection should only be sent in patients with urinary symptoms.

**5. Think twice about "UTIs" in patients with altered mental status.** Implement wait and see approach to non-specific symptoms of weakness, falls, fatigue, and/or delirium in elders, long term care residents, and patients with cognitive impairment before starting antibiotic for UTI

**6. Consider not prescribing antibiotics for uncomplicated abscesses.** Several studies conducted in the ED provide data to support withholding antibiotics after incision and drainage of uncomplicated abscesses, even in cases of suspected methicillin-resistant Staphylococcus aureus. One large RCT supports TMP/SMX use in abscesses.

**7. Avoid double coverage for community-acquired cellulitis.** TMP/SMX retains nearly 100% effectiveness vs. CA-MRSA. Wisconsin clindamycin resistance rates approaching 30%. No need to double cover uncomplicated cellulitis, single agent cephalexin is sufficient.

**8. Consider watch and wait prescriptions with acute otitis media.** Most otitis media is viral. Delaying treatment is usually associated with resolution of clinical signs and symptoms. Only 40% of watch and wait prescriptions are filled.

**9. Use procalcitonin to help guide decision to antibiose in COPD.** The FDA approved procalcitonin in 2017 to guide antibiotic initiation in LRTI.

**10. Avoid antibiotics for routine dentalgia.** Reversible pulpitis, periodontitis, and mechanical endodontic conditions present as tooth pain, but do not require antibiotics. NSAIDs and nerve blocks are recommended therapy. Antibiotics are appropriate if there is an adjacent space infection, trismus or odynophagia.

**Top Ten Ways for Emergency Physicians to Improve Antibiotic Choices (download)**

**1. Post-prescription culture review.** Ensuring that antibiotic coverage is sufficient limits adverse outcomes related to treatment failure, while narrowing coverage based on culture results enhances stewardship and reduce adverse medication reactions. We recommend utilizing non-physician staff for all aspects except antibiotic selection decisions.

**2. Antibiotic order sets and clinical decision support systems.** Institutions have successfully implemented strategies using written forms and, in some cases, computerized physician order entry to streamline the selection of empirical antibiotics in the ED. Ideally, such systems should be tailored to the patient based on data obtained during the evaluation (e.g., risk factors, comorbidities, etc)

**3. A multidisciplinary, antibiotic usage, quality improvement process.** Pharmacists and infection disease specialists can provide invaluable feedback and guidance on the optimal use and appropriate dosing of antibiotics in the ED.

**4. An antibiotic stewardship champion.** An ED Antibiotic Stewardship Champion can coordinate continuing education on antibiotic resistance/stewardship topics and may empower individual clinicians to utilize evidence-based guidelines rather than prescribe under pressure.

**5. An ED-specific antibiogram.** If your ED has sufficient volume, ED-based antibiograms can provide ED physicians with a comprehensive resource for clinical decision-making, especially with the development of more rapid molecular based testing for drug resistance.

**6. Consider cultures when initiating antibiotic therapy.** While the results of cultures obtained from blood, urine, and other potential infection sites are unlikely to return in the course of an ED stay, they play an important part in confirming infection and assuring that the causative microorganism is susceptible to the empiric antibiotic regimen initiated in the ED.

**7. Think twice before prescribing a macrolide for lower respiratory tract infection.** Macrolide (azithromycin) resistance in Midwest is around 50%. Consider a single agent regimen like doxycycline 100 mg BID x 5 days.

**8. Think twice before prescribing ciprofloxacin.** Fluoroquinolones are a major driver of *Clostridium difficile* outbreaks. They are less useful than ever with Midwest E. Coli resistance to ciprofloxacin averaging 82%. Detrimental side effects include tendonopathies, neuropathies and QT prolongation.

**9. Avoid combination therapy for ventilator-assisted pneumonia.** The use of two antibiotics against gram-negative infections is not routinely required, especially if empiric therapy involves an antipseudomonal penicillin, cephalosporin, or carbapenems.

**10. Use penicillin for dental infections.** Penicillin is the first choice for treating uncomplicated early ondontogenic infections. Coverage of anaerobes in these infections is only indicated with longer standing moderate to severe dental infections with adjacent space involvement.

Happy U.S. Antibiotic Awareness Week! For more information and clinical resources, visit https://www.cdc.gov/antibiotic-use/week/index.html

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## Other News

**Mental Health Committee Green Lights Emergency Detention Bill**
*November 8, Wisconsin Health News*

The Assembly's mental health reform committee has unanimously approved a bill that would prohibit law enforcement from transporting an individual to emergency detention from an emergency room unless a hospital or medical staff member gives the OK.

The bill, a result of about three years of negotiation with the Wisconsin Counties Association and the Wisconsin Hospital Association, also extends immunity under the emergency detention statute to healthcare providers. Read more.