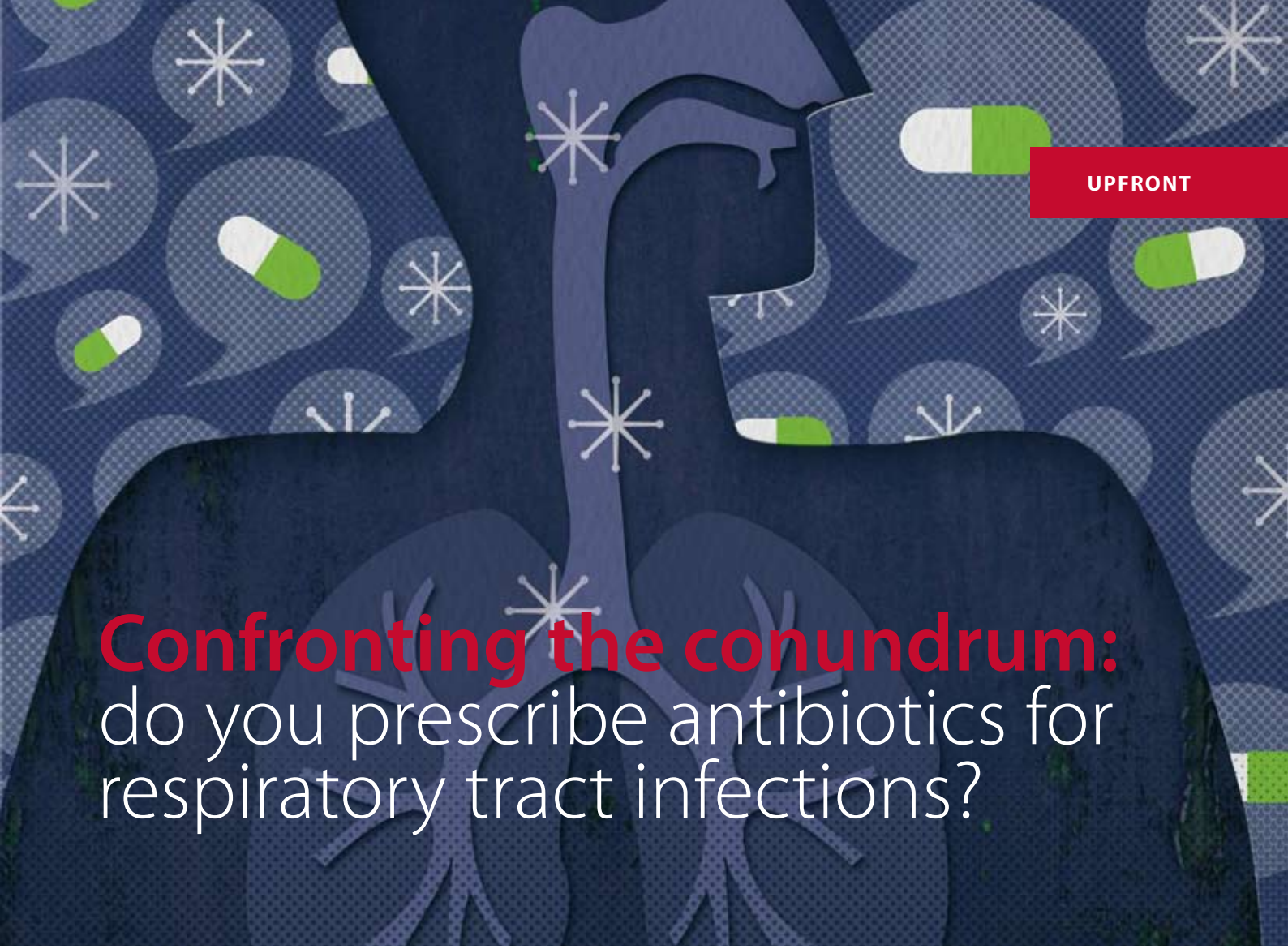

Confronting the conundrum: do you prescribe antibiotics for respiratory tract infections?

The June edition of Best Practice Journal (BPJ 68) was themed as an "Antibiotic Issue". It is increasingly important that we focus on sensible antibiotic prescribing in light of the rising levels of antimicrobial resistance, and the impending "antibiotic apocalypse". But what does sensible prescribing actually mean?

For some situations it is relatively easy to decide that an antibiotic is not necessary, but in other scenarios, it is much more difficult to make the best clinical decision. Take for example the current influenza season in New Zealand. Waiting rooms are full of patients, who have "dragged themselves from their beds" to come to see their general practitioner – some may even be back for their second or third visit because they are just not getting better. When does it become appropriate to prescribe an antibiotic in this scenario?

We want to create a situation where prescribers are confident and comfortable in their decision to prescribe antibiotics. But equally, we cannot bury our heads in the sand and do nothing about the sometimes unnecessary, detrimental and wasteful use of antibiotics. It is easy to follow rules, when rules can be made. However, there are usually exceptions to every rule, and in these cases it comes down to relying on your experience, your knowledge of the principles of antibiotic use and your clinical judgement.

The following selected reader feedback was received online in response to our antibiotic-themed issue, in particular our debate on prescribing antibiotics for respiratory tract infections:

"Just as every patient is different so is every doctor and we, therefore, vary in the degree of comfort we have with a particular strategy. I have trialled and since abandoned the back pocket prescription strategy. Having taken note of my patient's concerns, done an examination and explained to the patient how reassuring the findings were, declared a diagnosis of viral infection, and sympathetically explained that antibiotics are of no value in their case and can lead to side-effects it seemed incongruent to then give a prescription of antibiotics. I felt it gave the message 'but I might be wrong' or 'if you don't get better, don't come back and see me'."

"In Northland we have the issue regarding rheumatic fever. The expectations for antibiotics differ in certain demographics and

reasonably so. However, despite all the antibiotic prescribing, Group A strep has not developed resistance to penicillin. I would suggest that the majority of emerging resistance is related to the hospital antibiotic prescribing to immunosuppressed patients with chronic problems and frequently with open wounds. Antibiotics are used indiscriminately in the farming industry and they are the same antibiotics we use to treat patients. Last year was a particularly bad year for pneumonia, and I struggle with denying patients potentially life-saving medication, when GP access can be limited both due to availability and cost on a premise that I am not entirely convinced is accurate."

"This whole issue of inappropriate prescribing of antibiotics for RTIs has been known about for decades since the 1970s but the fact that research continues on this and that bpac^{nz} has to keep publishing the likes of the above [the RTI prescribing debate] merely shows that traditional ways of changing doctor behaviour don't work. What about some education on the best ways to change the prescribing habits of the recalcitrant antibiotic prescribers?"

"I think more patients are happy not to receive an antibiotic these days, but some continue to be demanding and can be hard to resist. What about some public patient education on TV, especially prior to/during the annual 'flu' season."

"I find it easier to get patients on side with less antibiotics by reframing the problem from a community issue (i.e. antibiotic resistance) to a personal issue, i.e. 'we don't want to make it too easy for your immune system otherwise it might not be able to deal with a more serious infection next time'. It's all about patient centredness!"

"When a patient presents with a RTI I would take a history and examine them. If it looked to be likely a viral infection rather than pneumonia, whooping cough, bronchiectasis or infectious exacerbation of COPD with change in colour of sputum, I would discuss the likely cause of symptoms, symptomatic treatment, rest, hygiene/infection control, and when to return if things didn't improve. I worked in a practice with a 50% Indian population who had a high expectation with antibiotics so I often used the back pocket script. While this sometimes caused confusion it helped me reduce the rate of antibiotic prescription by about 50%. I have sometimes stopped antibiotics early, but usually for an adverse reaction like upset stomach, rash, nausea. There weren't any negative outcomes."

"Often patients just need reassurance rather than antibiotics, but this necessitates a full examination followed by the information that antibiotics are unnecessary and will not make them feel better. But always offer to review if symptoms change or worsen."

"I feel that the presentation of patients in the practice has subtly changed over the years and I tend to see less of the obvious viral infections unless they need a medical certificate. Also the concept of back pocket scripts has helped enormously. I do worry about the local ED which often sees children out of hours despite there being an on call GP available . Often scripts for broad spectrum antibiotics are issued with minimal reason."

Appropriate antibiotic prescribing is going to continue to be a topic for discussion in New Zealand and worldwide. There are a multitude of factors that influence our prescribing decisions and also the patients' behaviour – the skill is to walk the right line and obviously there will be many different approaches taken to achieve this. The collective experience of the profession can help individual prescribers make the best decisions on a case-by-case basis. We encourage you to continue to contribute to this discussion. If you have found particular strategies that work well in your practice, consider sharing these suggestions online at: **www.bpac.org.nz/conundrum**

Further reading

"It's easy to prescribe antibiotics. It takes time, energy and trust not to do so". Dr Margaret McCartney, a general practitioner from Glasgow, provides an interesting viewpoint in the BMJ:

Blaming doctors won't reduce antibiotic overuse. BMJ 2015;351:h4697. Available from: **www.bmj.com/content/351/bmj.h4697**