

# But I'm Sick! Where's My Script?



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The approach of fall brings changes in weather and the start of school and (often) new jobs—with the requisite associated illnesses. Exposure to new germs makes us vulnerable to “catching everything.” Prime candidates for this phenomenon are children just entering school, who are magnets for the myriad pathogens lurking in classrooms and are quite adept at carrying them home to “share” with the family! As a result, upper respiratory infections (URIs) are common at this time of year.

With symptoms ranging from rhinorrhea, pharyngitis, and cough to difficulty breathing and fatigue, URIs are among the most frequent reasons for visits to health care providers and a leading cause of missed school or work in the United States.<sup>1</sup> The combination of bothersome symptoms and lost productivity is often the impetus for a request for antibiotics. Distressingly, these requests all

becoming increasingly resistant to first-choice antibiotics. This places both individual patients and society at risk for severe infections acquired in either health care facilities or the community.<sup>2</sup>

In the US alone, each year there are at least 2 million antibiotic-resistant infections, with more than 20,000 deaths as a result.<sup>3</sup> Among the major causes of resistance are overuse and misuse of antibiotics. Data indicate that 50% of hospitalized patients who are given antibiotics will receive unnecessary or redundant therapy, resulting in overuse. In the primary care setting, antibiotic overuse is associated with antibiotic resistance at the individual patient level.<sup>3</sup> What is most concerning is that “the presence of antibiotic-resistant bacteria is greatest during the month following a patient’s antibiotic use and may persist for up to 12 months.”<sup>3</sup>

The Global Antibiotic Resistance Partnership has identified four major reasons for inappropriate antibiotic prescribing and overuse. Although the particular findings came from a study in India, I submit that two of the reasons are applicable to the US: patients’ expectations and the lack of awareness about the inappropriate use of antibiotics and its associated risks.<sup>4</sup>

Since the early 1980s, global efforts have attempted to address these issues and provide solutions, which include judicious use of antibiotics in an attempt to stem the rising tide of bacte-

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too frequently result in unnecessary—and inappropriate—prescriptions.

Why is this a big deal? According to the World Health Organization, bacterial infections, including respiratory tract and hospital-acquired infections, are

rial resistance. The Alliance for the Prudent Use of Antibiotics, affiliated with Tufts University School of Medicine, has devoted 30-plus years to research, education, and public policy advocacy on this topic.<sup>5</sup> The CDC has an ongoing public service campaign, Get Smart About Antibiotics, to educate the general public about when antibiotics are appropriate and when they are not. And yet ...

Not surprisingly, antibiotic overuse occurs most often among patients with common respiratory ailments. We as clinicians know that URIs caused by viruses are self-limited and thus require no specific treatment—especially not antibiotics. Yet, perhaps for the following reasons—the patient doesn't want to “suffer” with the URI (which lasts between three and 14 days) or insists that he/she only gets better when taking antibiotics, or it is simply easier to concede than spend the extra time to explain why an antibiotic is not indicated (or effective) for viral infections—we write the prescription. Thus, we contribute to the problem.

We, as health care professionals, know better. We are armed with not only education and information that tells us when we should not prescribe an antibiotic, but also, increasingly, with recommendations and admonitions not to do it. These include

- One of the goals of *Healthy People 2020* is to “increase immunization rates and reduce preventable infectious diseases.”<sup>6</sup> Goal IID-6 is specific: “Reduce the number of courses of antibiot-

ics prescribed for the sole diagnosis of the common cold.”<sup>6</sup>

- The Institute of Medicine has identified six key issues that must be addressed in today's health care systems, including safety and effectiveness of care. Safety involves “avoiding injuries to patients from the care that is intended to help them.”<sup>7</sup> Surely avoiding inappropriate use of antibiotics qualifies.

I'm not suggesting we should never prescribe antibiotics; we all know there are instances in which it is absolutely appropriate: in patients who are immunocompromised and in cases when we suspect strep throat, bacterial sinusitis, or epiglottitis. When we have these clinical suspicions, we need to obtain cultures to confirm them. And if treatment is the right course, we should prescribe the right antibiotic at the right dose for the right duration and be familiar with regional resistance trends.<sup>3</sup>

We—as primary care providers—can easily mitigate the global threat of antibiotic-resistant bacteria if we encourage symptomatic therapy for URIs: those simple, “tried and true” treatments. We know them, our patients know them, and just in case we forget, we have seasonal commercials to remind us. The treatment for the average URI is simple: Rest in bed, drink plenty of fluids, and take nonprescription medications to attenuate symptoms such as fever or myalgia. (For helpful patient education, see “When Patients Ask for Antibiotics, Arm Them With

Handouts,” page 33.)

We must base our decision whether to treat common URI complaints with antibiotics on sound clinical findings. Take the time to explain to your patients those findings and educate them about appropriate use of antibiotics. Moreover, when the clinical findings do not support the need for an antibiotic, tell your patients, “I'm not saying you aren't sick; I'm telling you that you don't need antibiotics for your illness!” Remind patients that they will get better, as one colleague of mine always said, “in seven days with, or in a week without, antibiotics.”

So, when you must, write the prescription. But please: Prescribe “tincture of time.” **CR**

## REFERENCES

1. Johns Hopkins. Upper respiratory infection (URI or common cold). [www.hopkinsmedicine.org/healthlibrary/conditions/pediatrics/upper\\_respiratory\\_infection\\_uri\\_or\\_common\\_cold\\_90,P02966/](http://www.hopkinsmedicine.org/healthlibrary/conditions/pediatrics/upper_respiratory_infection_uri_or_common_cold_90,P02966/). Accessed August 14, 2014.
2. World Health Organization. Antimicrobial resistance. [www.who.int/mediacentre/factsheets/fs194/en/](http://www.who.int/mediacentre/factsheets/fs194/en/). Accessed August 14, 2014.
3. CDC. Delivering smart care for patients: all healthcare providers play a role. [www.cdc.gov/getsmart/healthcare/factsheets/hc\\_providers.html](http://www.cdc.gov/getsmart/healthcare/factsheets/hc_providers.html). Accessed August 14, 2014.
4. Global Antibiotic Resistance Partnership (GARP) India Working Group. Rationalizing antibiotic use to limit antibiotic resistance in India. *Indian J Med Res*. 2011;134(3):281-294.
5. Alliance for the Prudent Use of Antibiotics. [www.tufts.edu/med/apua/about\\_us/what\\_we\\_do.shtml](http://www.tufts.edu/med/apua/about_us/what_we_do.shtml). Accessed August 14, 2014.
6. United States Department of Health and Human Services. Immunization and infectious disease. [www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=23](http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=23). Accessed August 14, 2014.
7. The Institute of Medicine. An agenda for crossing the chasm. In: *Crossing the Quality Chasm: A New Health System for the 21st Century*. 2001:5-6. [http://books.nap.edu/openbook.php?record\\_id=10027&page=5](http://books.nap.edu/openbook.php?record_id=10027&page=5). Accessed August 14, 2014.