



The CDC's new report on the growing danger of antibiotic resistant organisms is the subject of this month's audiocast, "Combatting drug resistance: What you can do" at jfponline.com

An instructive tale about "hamburgers"

As coach of a youth team, I used to take the kids to a hamburger stand after each game. The owner always greeted me warmly. "Hey doc, how many burgers today?"

"Eleven," I said one day.

The owner looked distressed. "Hmm. I might not have that many."

"I have 11 hungry kids," I interjected. They'll be disappointed if they don't each get a burger. This was our last game, you know."

"I'll check again," he replied. Soon he returned with 11 burgers. "Got lucky. Sorry about the scare."

"No problem. That's why I come here. I always get what I want."

The next day a player's mom called to say her son had diarrhea and was vomiting. "Could it be food poisoning?" she asked.

I told her I would find out.

I called the hamburger stand owner and told him that one of the kids was sick, and asked if the burgers could be responsible. To my surprise, he said Yes.

"Remember, I didn't think I had enough burgers, then came back with 11?" he said, without a hint of distress. "Well, I only had 10 that I knew were good. The 11th burger had been sitting around for a few hours. I thought it might be bad, but decided to take the chance."

"You *what*?" I asked, incredulous.

"You know I always try to keep my customers happy. What's the fuss? Only one kid got sick, and all he got was a little diarrhea."

Needless to say, I was flabbergasted. How much irresponsibility did he think was acceptable in the name of satisfaction?

Whenever I tell this story, the response is usually an incredulous look and a recommendation that the owner of the hamburger stand be boiled in oil.

Then I tell the truth: This incident never happened. It's a parable I like to tell residents when we discuss the unnecessary use of antibiotics. You see, if you replace the word "hamburger" with "antibiotic," and replace "stand owner" with "family doctor," the story is virtually the same.

When we give patients unnecessary antibiotics just to keep them happy, we are

doing exactly what the owner did. Same principle, and same consequences. So why do most doctors think the hamburger story is ghastly, yet continue to prescribe unnecessary antibiotics?

Studies indicate that nearly 50% of antibiotics are unnecessary,^{1,2} but some patients are happier when we prescribe them. Yet antibiotics have a number needed to harm (NNH) of about 10, if we define harm as antibiotic-associated diarrhea³—about the same NNH as in the hamburger story. (That's without counting the growing threat of antibiotic-resistant organisms, the topic of a new CDC report⁴ and this month's audiocast.)

So the next time you're tempted to prescribe an unnecessary antibiotic to keep a patient happy, hand the patient a copy of this story instead.

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3. Turck D, Bernet JP, Marx J, et al. Incidence and risk factors of oral antibiotic-associated diarrhea in an outpatient pediatric population. *J Pediatr Gastroenterol Nutr*. 2003;37:22-26.

4. Antibiotic/antimicrobial resistance. Threat report 2013. Centers for Disease Control and Prevention Web site. Available at: <http://www.cdc.gov/drugresistance/threat-report-2013>. Accessed October 14, 2013.

Readers weigh in on venous ulcer treatment

In "What is the best initial treatment for venous stasis ulcers?" (Clinical Inquiries. *J Fam Pract*. 2013;62:433-434), Dr. Poynter et al seemed to say that various kinds of compression stockings are suitable. What about going back to the Unna boot?

I have had great success treating venous stasis ulcers with the Unna boot. This calamine-infused gauze dressing, which can easily be applied in a primary care setting, has been replaced by wound treatments that are much more expensive—and may be less effective. Cost matters, and all things being equal, it's time to promote the Unna boot once more.

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OVERDOSAGE

Although rare, deaths may occur from overdosage with AMRIX. Multiple drug ingestion (including alcohol) is common in deliberate cyclobenzaprine overdose. **As management of overdose is complex and changing, it is recommended that the physician contact a poison control center for current information on treatment.** Signs and symptoms of toxicity may develop rapidly after cyclobenzaprine overdose; therefore, hospital monitoring is required as soon as possible.

DOSAGE AND ADMINISTRATION

The recommended adult dose for most patients is one (1) AMRIX 15 mg capsule taken once daily. Some patients may require up to 30 mg/day, given as one (1) AMRIX 30 mg capsule taken once daily or as two (2) AMRIX 15 mg capsules taken once daily.

It is recommended that doses be taken at approximately the same time each day. Use of AMRIX for periods longer than two or three weeks is not recommended (see **INDICATIONS AND USAGE**).

Dosage Considerations for Special Patient Populations: AMRIX should not be used in the elderly or in patients with impaired hepatic function. (see **WARNINGS**)

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Author response:

My coauthors and I appreciate the comments of Drs. Mayer and Hansen. Regarding the cost effectiveness and utility of the Unna boot, we would point out that the focus of our Clinical Inquiry was on the initial management of venous stasis ulcers and how best to promote healing.

Little data exist on Unna boot application alone. But it is likely that many of the compression therapy modality studies in the Cochrane meta-analysis included in our review featured Unna boot dressings as part of some form of multilayer compression therapy being evaluated.¹



Compression alone has a poor long-term outcome for the healing of ulceration.

As Dr. Hansen observes, compression, the standard compression classes, and the minimal benefits of low pressure levels provided by the classic TED hose and OTC support hose should have been addressed. This information was not included in our review due to space limitations. This subject deserves a dedicated article, as there is a great deal of confusion about terminology and types of dressings.

Both the 2009 Cochrane meta-analysis¹ and a 2012 update² found that adding a component of elastic compression therapy results in faster ulcer healing compared with inelastic compression therapy alone. Venous ulcers treated with 4-layer bandages heal faster, on average, than those treated with short stretch bandages, and regular use of compression stockings lowers the risk of recurrence.³ Correcting underlying venous incompetency issues is certainly a consideration, particularly for ulcers that initially heal but later recur.

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LETTERS

Venous ulcer treatment

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As a family physician certified by the American Board of Venous and Lymphatic Disease, I would like to point out a couple of things.

First, while the authors discussed compression, they did not define what that meant. This is important, as many physicians prescribe TED hose for venous stasis ulcers, although it does not provide enough compression.

Secondly, fixing the underlying problem should be considered part of the initial treatment. Studies show that a combination of compression and intervention is the best way to ensure long-term healing of venous stasis ulcers.^{1,2} I would recommend that such patients be referred to a phlebologist for evaluation. Compression alone has a poor long-term outcome for the healing of ulceration.

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