Letters to the Editor

Online-Only Letters to the Editor

Acupuncture May Be Helpful for Patients with Plantar Fasciitis
Michael Solomon, MD, MBA, with reply by James Goff, DO, FAAFP, CAQ (http://www.aafp.org/afp/2012/0515/ol1.html)

Qualitative Benefits of Screening for Intimate Partner Violence
Sarah Kureshi, MD, MPH, and Kim Bullock, MD, with reply by Peter F. Cronholm, MD, MSCE; Colleen T. Fogarty, MD, MSc; Bruce Ambuel, PhD, MS; and Suzanne Leonard Harrison, MD (http://www.aafp.org/afp/ 2012/0515/ol2.html)

Send letters to Kenneth W. Lin, MD, Associate Medical Editor for *AFP* Online, e-mail: afplet@aafp.org, or 11400 Tomahawk Creek Pkwy., Leawood, KS 66211.

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Local Antibiograms Can Reduce Inappropriate Antibiotic Prescribing

Original Article: Diagnosis and Treatment of Acute Pyelonephritis in Women

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Available at: http://www.aafp.org/afp/2011/0901/p519.html

TO THE EDITOR: As the infection control chair at a 25-bed critical access hospital, I read this article on pyelonephritis with interest. I am concerned about the message that primary care physicians might receive from your choice of wording in the abstract: "Practice guidelines recommend oral fluoroquinolones as initial outpatient therapy if the rate of fluoroquinolone resistance in the community is 10 percent or less. If the resistance rate exceeds 10 percent, an initial intravenous dose of ceftriaxone [Rocephin] or gentamicin should be given, followed by an oral fluoroquinolone regimen." Although factually accurate, this statement may discourage busy physicians from consulting local antibiograms to ensure excellent treatment. It is counterproductive to mention a specific class of antibiotics when awareness of the local antibiogram is the first decision point in the process.

In our community, as in most, *Escherichia coli* makes up the majority of pathogens in healthy young women. Our resistance rates are nearly 25 percent for fluoroquinolones and 4 percent for cephalosporins. These rates are similar to those in many other communities in this country, and research is revealing escalating fluoroquinolone resistance.[1,2] Less savvy prescribers often tell me they use fluoroquinolones because that is the recommendation, not reading the subsequent caveat. I suggest an alternative approach—emphasizing the importance of relying on local antibiogram patterns and allowing for appropriateness of multiple classes of drugs. Doing so would improve the quality of care by decreasing the likelihood of inappropriate prescribing and poor antibiotic stewardship.

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REFERENCES

1. Boyd LB, Atmar RL, Randall GL, Hamill RJ, Steffen D, Zechiedrich L. Increased fluoroquinolone resistance with time in *Escherichia coli* from > 17,000 patients at a large county hospital as a function of culture site, age, sex, and location. *BMC Infect Dis.* 2008;8:4.
2. Johnson L, Sabel A, Burman WJ, et al. Emergence of fluoroquinolone resistance in outpatient urinary *Escherichia coli* isolates. *Am J Med.* 2008;121(10):876-884.

IN REPLY: We are pleased that our article has stimulated interest in this topic, and agree that local antibiograms can reduce inappropriate antibiotic prescribing.

Dr. Lambke is concerned about the message physicians might receive from our choice of wording on prescribing antibiotics for the treatment of pyelonephritis. As he notes, this is faithful to the guidelines from the Infectious Diseases Society of America (IDSA).[1] We doubt that rephrasing would persuade a physician who is not focused on properly following this guideline to do otherwise. The IDSA guidelines do not offer an alternative approach for physicians who are too busy to check the local antibiogram, as recommended.

We believe that awareness of the local antibiogram is implicitly necessary to follow these guidelines. Unfortunately, the typical local antibiogram is from the local hospital and amalgamates all *E. coli* and other isolates, regardless of specimen type, host demographics, clinical syndrome, and patient location (e.g., intensive care unit, emergency department, inpatient ward, clinic). Because susceptibility patterns can vary considerably according to these factors, physicians need cumulative susceptibility data derived from the relevant patient population for optimal prescribing. Such data are ▶

rarely available, even to physicians who are motivated to incorporate them into their decision making.

Ultimately, we are responsible for our own prescribing habits. How journal articles or guidelines are written is unlikely to change behaviors unless the reader wishes to change.

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REFERENCE

1. Gupta K, Hooton TM, Naber KG, et al. International clinical practice guidelines for the treatment of acute uncomplicated cystitis and pyelonephritis in women: a 2010 update by the Infectious Diseases Society of America and the European Society for Microbiology and Infectious Diseases. *Clin Infect Dis.* 2011;52(5):e103-e120.

Corrections

The article, "End-Stage Renal Disease: Symptom Management and Advance Care Planning" (April 1, 2012, page 705), contained two errors. In Table 3 on page 708, the dosage for fentanyl was incorrectly listed as 12.5 mg. The correct dosage for fentanyl is 12.5 mcg intravenously or subcutaneously every two hours as needed. The brand name Duragesic was also incorrectly added to fentanyl in Table 3, and in several locations throughout the article. Fentanyl should have been listed without a brand name. The online version of this article has been corrected.

In the "Cochrane for Clinicians" titled "Opioid Antagonists for the Treatment of Alcohol Dependence" (November 1, 2011, page 990), the relative risk and confidence interval for oral naltrexone reducing the risk of return to heavy drinking were incorrect in the second paragraph of the right-hand column on page 990 and in the abstract on page 991. The text should have read: "Compared with placebo, oral naltrexone reduced the risk of return to heavy drinking by 17 percent (relative risk [RR] = 0.83; 95% confidence interval [CI], 0.76 to 0.90)… ." In the "Main Results" section of the abstract, the first sentence should have read: "Based on a total of 50 randomized controlled trials with 7,793 patients, naltrexone reduced the risk of heavy drinking to 83 percent of the risk in the placebo group (relative risk [RR] = 0.83; 95% confidence interval [CI], 0.76 to 0.90)… ." The online version of this article has been corrected.

The article, "Treatment and Prevention of Kidney Stones: An Update" (December 1, 2011, page 1234), and the accompanying patient education handout, "Preventing Kidney Stones with Diet and Nutrition" (December 1, 2011, page 1243), contained multiple errors. In the first full paragraph of the right-hand column on page 1236, the second sentence listed "black race" as a traditional risk factor for chronic kidney disease. The sentence should have read: "Persons with kidney stones are more likely to have traditional risk factors for chronic kidney disease (e.g., hypertension, preexisting kidney disease, diabetes, proteinuria, albuminuria)." The first line of Table 4 (page 1237) under the "Type of medication" column should have listed "Agents that decrease uric acid production" rather than "Agents with uricosuric properties." Two of the section headers on page 1241 contained incorrect words: "How can urine be alkalinized (decrease urine pH)?" should have read "How can urine be alkalinized (higher urine pH)?" and "How can urine be acidified (increase urine pH)?" should have read "How can urine be acidified (lower urine pH)?" In the patient education handout, the section on "Uric Acid Stones" at the bottom of the right-hand column on page 1243 was misleading regarding the formation of uric acid stones and the effect of citrus juice on urine. The paragraph should have read: "Uric acid stones form in acidic urine and account for approximately 17 percent of kidney stones. Alkalinizing the urine with citrus juice, decreasing protein intake, avoiding beer and alcohol, and reducing fructose intake are all opportunities for prevention. Do not drink cranberry juice or take betine—both of these will acidify the urine." The online versions of this article and patient education handout have been corrected. ■