The Prudent Prescriber

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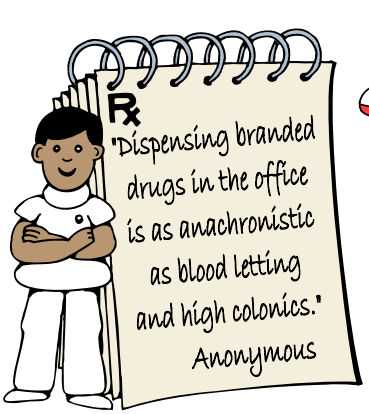


20 years of the Prudent Prescriber

In April 1998, in a chicken-scratched font, the 'catchily' named FPWC Pharmacology Literacy Foundation, forerunner of the Prudent Prescriber, bellowed its first headline,

"Sex Sells Newsletters"

The lead story focused on the hard facts of a newly approved drug, sildenafil (Viagra).

As we move into the third decade of the Prudent Prescriber, the educational goals remain the same:
"Provide in-the-trenches, practical, unbiased, cost-effective prescribing information for primary care physicians."

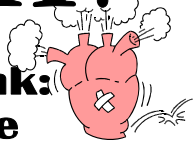
"Unbiased," conflict of interest free communication is a huge issue in this milieu of "Fake News." In nearly 250 newsletters, neither the management, nor the clinical pharmacists at Rocky Mountain Health Plans (who pay me a stipend to create this newsletter) have ever edited or killed an article. (Thankfully, the Rocky Pharm D's have bailed me out on multiple occasions when I misstated a dose or misinterpreted a study.)

Pharm Reps ≠ Rational Prescribing
(PR)  **(RP)**

Antibiotics do NOT

help acute bronchitis

CHF?

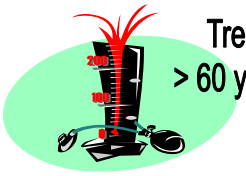


Think:
Ace
Aldactone
B-blocker
Dig
Diuretic

ß-blockers in post-MI save lives

Avoid these expensive "me-too" drugs:

Intermezzo
Vimovo
Livalo
Gralise
Viibyrd
Edarbi
Daliresp



Treat patients > 60 years to 150/90

Pill splitters save BIG

NOW AVAILABLE ON THE GENERIC MARQUEE

Viagra→sildenafil
Effient→prasugel
Strattera→atomoxetine
Asacol HD→mesalamine DR
Pristiq→desvenlafaxine

The biases in this newsletter are entirely mine:
* less is more, bordering on nihilism.
* the FDA sleeps with Big Pharma, and therein the FDA often does not have the needs of our patients at heart.
* buying your medications in Canada is safe and cost-effective.
* I fully subscribe to Sir William Osler's aphorism, "The first duty of the physician is to teach patients not to take medicines."

In the last 20 years my skepticism has become robust. My sense of humor remains frozen in the 5th grade. I welcome your feedback.

Pharma Pearls from San Francisco

Each March I train to San Francisco for twenty hours of CME with a focus on reviewing the medical literature with particular emphasis on "game changers" in clinical medicine. Here are the 2018 pharmaceutical pearls.

Ψ There is an association between adjunctive **steroid use in community acquired pneumonia** (CAP) and improved outcomes. Steroid treated patients had less respiratory failure (4% versus 18%), shorter duration of intubation, shorter ICU stays and more rapid improvements than control patients. [Crit Care 15(2):R96, March 15, 2011]. In another randomized, controlled study of CAP patients, adding 50mg of prednisone for five days decreased the average hospital stay from seven days to six days. [Lancet, 385(9977); 1511, April 18, 2015]

Ψ **Use cephalexin alone in uncomplicated cellulitis.** In a double blind study (Moran, JAMA 317(20): 2088, May 23, 2017) 496 patients over the age of 12 years presenting to five emergency rooms with uncomplicated cellulitis (erythema without abscess, purulent drainage or wound) randomized to a seven day course of cephalexin (500mg four times daily) plus trimethoprim-sulfa, four single strength pills 80/400, twice daily) or cephalexin alone. Followed up to 63 days, the clinical cure rates at 14 to 21 days were 83.5% of patients randomized to the two drug combination and 85.5% in those randomized to cephalexin alone. There were no significant differences between the groups in secondary outcomes: the need for a drainage procedure, invasive infection or new infection at a different site.

Ψ Ever try to pack and then unpack a superficial abscess in a kid? It hurts!! This study (J Ped Surg 43: 1962, 30130) from a Children's Hospital in Kalamazoo randomized 100 immuno-competent, non-diabetic kids who had undergone an I & D of a subcutaneous abscess. Half the kids had packing that was removed 24 hours later. The children in both groups were treated with 7 days of trimethoprim-sulfa. Abscess recurrence developed in one patient in each group. **Wound packing has no apparent beneficial effect in immune-competent children undergoing incision and drainage of subcutaneous abscesses.**

Ψ I have long lobbied against muscle relaxants (they are not; they are soporifics) and benzodiazepines in muscular syndromes. In this study (Ann Emerg Med Epub Jan19, 2017) from Montefiore Medical Center, 114 adults with non-radicular, non-traumatic low back pain of two weeks duration or less were randomized to treatment with naproxen alone or naproxen plus diazepam. At one week, the pain score improvements were the same in the two groups. Most patients had recovered by three months, with no differences between groups in pain and function. **Don't add "muscle relaxants" to analgesics in the treatment of low back pain.**

Ψ This Dutch study (British Journal of Surgery 104 (1): 52, in January 2017) reminded me of how many patients with diverticulitis I made sicker with antibiotics. This was a 22 site, open label study of 570 patients with a first episode of CT proven, uncomplicated, left-sided acute diverticulitis. The patients were randomized to a 10 day course of amoxicillin-clavulanic acid or observational management. Results: the median time to recovery was 14 days in the observational treatment group versus 12 days

in the antibiotic treatment group. During six months of follow-up, there were no significant differences between the two groups with respect to patient recovery, readmission, complicated diverticulitis, ongoing diverticulitis, or sigmoid resection. Antibiotic treatment was associated with anaphylactic shock in one patient. The median hospital stay was shorter in the observation treatment group.

Ψ There are now multiple studies that demonstrate that acetaminophen offers comparable pain relief as NSAIDs in multiple pain syndromes, including non-specific low back pain. Acetaminophen's side effect profile is benign compared to NSAIDs.

There are, however, 3 or 4 conditions where NSAIDs are the drugs of choice.

1. **Rheumatoid disease**
2. **Colic**
3. **Menstrual cramps**
4. **? pericarditis**

Vaccine Update

Yellow Fever:

- In June 2016, the World Health Assembly removed the 10 year booster requirement. The ACIP recommendation is for a single primary dose of yellow fever (YF) vaccine, stating that it provides long-lasting protection for most travelers.
- Manufacturing problems have resulted in depletion of YF-VAX (the only YF vaccine used in United States). As a result, many public health facilities and immunization clinics have run out of YF vaccine. The CDC and FDA agreed to import Stamaril, produced in France. Stamaril has an efficacy and safety profile similar to YF-VAX.
- As of early June, 2018, Stamaril is not widely available. The CDC website, https://wwwnc.cdc.gov/travel/yellow-fever-vaccination-clinics/state/colorado is a place to start, but call to be sure that the site has vaccine available!

Hepatitis B:

- In February 2018, the ACIP approved a new two dose Hepatitis B vaccine for those 18 years and older.
- Studies show improved efficacy of HEPLISAV-B over the older three dose regimen. In one study of the older vaccine, only 13% of those receiving the first dose received the third dose. HEPLISAV-B is given in two doses a month apart.

Mumps:

- The US continues to experience outbreaks of mumps among adults.
- For adults who have previously received two or fewer doses of mumps containing vaccine and are identified as being at increased risk for mumps in an outbreak, administer one dose of MMR.

Herpes Zoster:

- See the December 2017 Prudent Prescriber for a review of Shingrix.