The Prudent Prescriber

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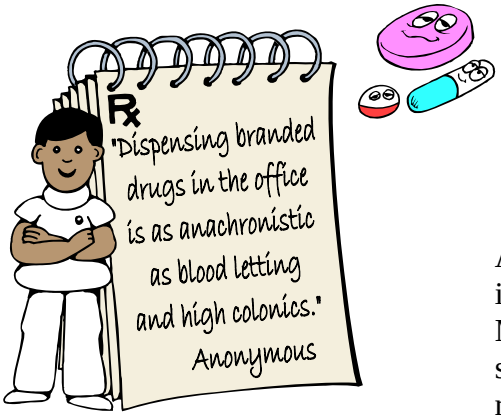


September 2018

Pharm Reps ≠ Rational Prescribing (PR) (RP)

Travelers' Diarrhea
Guidelines for Prevention and Treatment

A fun part of my clinical world these days involves learning from the epidemiologists at the Mesa County Public Health Department. This summer we have had a steady stream of reportable diarrheal illnesses—many of them a consequence of travel.

Riddle and colleagues' paper {Journal of Travel Medicine 24(Supplement 1): S63, April 1, 2017} is a useful multinational clinical practice guideline on the prevention and management of diarrhea. A summary of the highlights:

Travelers' diarrhea definitions:

Mild (acute): diarrhea that's tolerable, is not distressing, and does not interfere with planned activities.

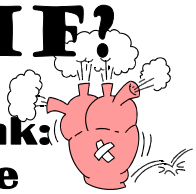
Moderate (acute): diarrhea that is distressing or interferes with planned activities.

Severe (acute): diarrhea that is incapacitating or completely prevents planned activities; all dysentery (passage of grossly bloody stools) is considered severe.

Persistent: diarrhea lasting > 2 weeks.

This guideline based on functional impact and not simply counting stools makes clinical sense.

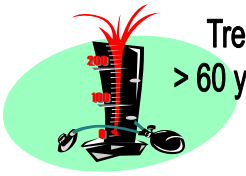
CHF?



Think:
Ace
Aldactone
B-blocker
Dig
Diuretic

Avoid these expensive "me-too" drugs:

Intermezzo
Vimovo
Livalo
Gralise
Viibyrd
Edarbi
Daliresp



Treat patients > 60 years to 150/90

Antibiotics do NOT

help acute bronchitis

ß-blockers in post-MI save lives

Pill splitters save BIG

NOW AVAILABLE ON THE GENERIC MARQUEE

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

Prophylaxis

- ❖Antimicrobial prophylaxis should **not** be used routinely in travelers (strong recommendation, low/very low level of evidence).
- ❖Bismuth subsalicylate (BSS) may be considered for any traveler to prevent travelers' diarrhea (strong recommendation, high level of evidence).
- ❖When antibiotic prophylaxis is indicated, rifaximin ($19.73 per Xifaxan 200mg tab) is recommended (strong recommendation, moderate level of evidence).
- ❖Fluoroquinolones are **not** recommended for prophylaxis of travelers' diarrhea (strong recommendation, low/very low level of evidence).

Therapy of mild travelers' diarrhea

- ❖ Antibiotic therapy is not recommended in patients with mild travelers' diarrhea (strong recommendation, moderate level of evidence).

Therapy of moderate travelers' diarrhea

- ❖ Azithromycin may be used to treat moderate traveler's diarrhea (strong recommendation, high level of evidence).
- ❖ Loperamide (Imodium) maybe considered for use as monotherapy in moderate travelers' diarrhea (strong recommendation, high level of the evidence).
- ❖ Fluoroquinolones may be used to treat moderate travelers' diarrhea (strong recommendation, moderate level of evidence and then with multiple qualifying remarks about resistance to this class of drugs, reduction of the diversity of intestinal microbiota and musculoskeletal consequences)

Therapy in severe travelers' diarrhea

- ❖ Antibiotics should be used to treat severe traveler's diarrhea and azithromycin is the preferred drug (strong recommendation moderate/high level of evidence).
- ❖ Both fluoroquinolones and rifaximin may be used to treat severe, non-dysenteric travelers' diarrhea (weak recommendation, moderate level of evidence). Neither is drug of choice in SE Asia.

Follow-up diagnostic testing/other

- ❖ Microbiologic testing is recommended in returning travelers with severe or persistent symptoms and those who fail empiric therapy (strong recommendation, low/very low level of evidence).
- ❖ There is insufficient evidence to recommend the use of commercially available prebiotics or probiotics to prevent or treat travelers' diarrhea.

My take:

- ➢ This paper is a pragmatic, state of the art guideline.
- ➢ There is a useful table recommending **single** doses of various antibiotics for treating acute diarrhea:
  - azithromycin 1000mg (total cost $3.40)
  - levofloxacin 500mg (total cost $0.90)
  - ciprofloxacin 750mg (total cost $0.40)
  - rifaximin 200mg tid x 3days (total cost $ 177)
- ➢ Most, if not all travelers, should be provided with loperamide and an antibiotic (my choice: azithromycin and only choice if you are going to SE Asia) for self-treatment. They should also be provided with the tactical information about when to start which drug(s) and their associated benefits and down sides.
- ➢ The CDC travel page (wwwnc.cdc.gov/travel/page/travelers-diarrhea) is an excellent resource for non-medicinal approaches to travelers' diarrhea.

Got a Distal Ureteral Stone?
Ask a Turkish Urologist!

This sexy study, hidden away in the journal {Int Urol Nephrol 49(11):1941, November 2017} offers an alternative or add-on to alpha blockers for the management of distal ureteral stones.

In this prospective Turkish study, 190 married men presenting with radiopaque distal ureteral stones measuring 5-10 mm were randomized to one of three treatment groups: (1) tamulosin 0.4 mg daily, (2) sexual intercourse at least three times per week, or (3) a control group receiving standard medical therapy. Standard therapy included instructions to consume sufficient liquids to produce urination of 1.5 – 2.0 L /day and diclofenac as needed for pain. Patients in the tamulosin and standard care groups were requested to avoid all sexual activity, including masturbation. Spontaneous stone passage was evaluated over four weeks.

Results: By 4 weeks, the rate of stone passage was 81.6% in tamulosin group, 81.8% in the sexual intercourse group, and 51.5% in the standard care group. (NNT =3) The mean time to stone expulsion was 9.3 days with tamulosin, 8.8 days with sexual intercourse group and 8.7 days in the standard controls group. When compared with controls, the sexual intercourse group had significantly lower analgesic requirements and both the tamulosin and sexual intercourse groups had significantly lower requirements for additional treatment.

My Take:
I have pondered a very long time deciding what to write or what not to write about this study. If I told you that the men in the study were not necessarily directed to their wives for intercourse and that there was no quality of life survey done among the sexual partners, you might claim puritanism, immorality or feminism on my part. If I told you that the study was not really randomly concealed, but simply placed stone laden men in the three groups consecutively and further told you that there was no attempt to measure the cross-over between the three groups, you might claim academic isolation from empathetic feelings. So, I'll just ask, "How amorous can you be while trying to pass a kidney stone?"

Influenza Immunization and Egg Allergy
An Update on Recommendations

I'm putting together this newsletter the first week in August and expect any day to see the "Flu shot" sign go out in front of the Safeway store down my street. (It did on August 8th!) One part of the immunization procedure that the grocery store pharmacists and all clinicians can eliminate this year is the question about egg allergy. The Influenza Vaccine and Egg Allergy Practice Parameter Workgroup updated their recommendations, published in {Ann Allergy Asthma Immunol 120(1): 49 January 2018}. Published data confirm the safety of inactivated influenza vaccine (IIV) and live attenuated influenza vaccine (LAIV) in egg allergic patients, including those with history of anaphylactic reactions to egg ingestion.

The Task Force states that **influenza vaccine should be given annually, in any approved brand and age appropriate dose, to those with egg allergy of any severity, just as they are given for non-allergic individuals, with no need for special questioning or other precautions (strong recommendation; evidence level A/B).**

Non-egg-based influenza vaccines (ccIIV3, RIV3 and RIV4) are acceptable for egg-allergic individuals, but not medically preferred (moderate strength recommendation; evidence level C/D). Finally it should be noted that both IIV and LAIV contain very low levels of ovalbumin that are highly unlikely to cause reactions and that allergic reactions and rarely anaphylaxis remain possible with any vaccine regardless of egg allergy status.

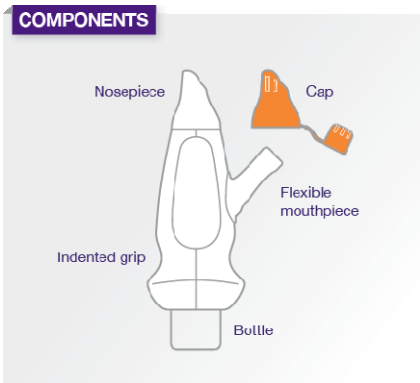
Gonorrhea: Increasing Antibiotic Resistance
Use Two Drugs

In the past we often used a combination of ceftriaxone plus azithromycin to treat gonorrhea with thoughts of covering a coexisting chlamydia infection. Now dual therapy with both **ceftriaxone 250mg IM PLUS azithromycin one gram orally** is crucial for uncomplicated genital, pharyngeal and rectal gonorrhea. In patients allergic to azithromycin, substitute doxycycline 100mg BID for 7 days and push for adherence. Do not routinely use oral cefixime, as its efficacy is declining steadily.

There haven't been any documented treatment failures in the US. However, the growing number of international reports of cefixime treatment failures, and the bacteria's history of becoming resistant to antibiotics used for treatment point to the increasing likelihood that gonococcal cephalosporin resistance and treatment failures are on the horizon in the United States.

Rube Goldberg Attacks Nasal Polyps: Xhance

This gadget is a new approach to the treatment of nasal polyps. Xhance has a nose piece and a mouth piece. The patient blows hard into Xhance with her mouth while actuating the spray into the nostril. The concept is that exhalation forces the steroid deeper into the nose and closes off the throat so less medicine is swallowed.



However, the manufacturer, OptiNose US, Inc. has not provided any evidence that this device (Xhance 93mcg fluticasone one spray/nostril BID. $443/ month) works any better than OTC fluticasone 50mcg 2 sprays/nostril BID (Amazon Prime $17.48/month).

You may access previous issues at https://www.rmhp.org/i-am-a-provider/provider-resources/publications-for-providers.