Kingston GP Chambers

18/02/2021

Dear EH team,

Further to my letter last month highlighting the antibiotics audit we are undertaking I wanted to remind everyone to use the local formulary as much as possible (can be found on link below).

https://www.kingstonformulary.nhs.uk/page/29/5-infections-guidelines

Select – Primary Care: Management and treatment of Common Infections in Primary Care

From initial viewing there seem to be a few clinicians using trimethoprim as first line – please use nitrofurantoin, and if not document the reason for doing so. Over the next few weeks we will do a more detailed audit of use of broad spectrum antibiotics and will feed those results back.

Thank you to everyone who completed the self-assessment of antibiotic prescribing – if you didn't do this please have a look and sent it back to Laura or myself.

Clinical Commissioning Group

<table>
<tr><th>ILLNESS</th><th>DRUG OPTION</th><th>DOSE</th><th>DURATION</th><th>COMMENTS</th></tr>
<tr><td colspan="5">URINARY TRACT INFECTIONS
Note: As antibiotic resistance and Escherichia coli bacteraemia in the community is increasing, use nitrofurantoin first line, always give safety net and self-care advice, and consider risks for resistance. Give TARGET UTI leaflet, and refer to the PHE UTI guidance for diagnostic information.</td></tr>
<tr><td rowspan="5">Uncomplicated lower UTI (i.e. no fever or flank pain) in men & non-pregnant women 16 years & over

NICE NG109 UTI (lower): antimicrobial prescribing

PHE UTI Diagnosis

TARGET UTI

RCGP UTI

SIGN UTI

NHS Scotland UTI</td><td>1. Nitrofurantoin

OR

If low risk of resistance:
Trimethoprim</td><td>100mg m/r BD (BD dose preferred due to increased compliance)
OR
50mg i/r QDS

200mg BD</td><td>Women: 3 days
Men: 7 days</td><td rowspan="5">Self-care advice:
• Advise paracetamol or ibuprofen for pain & drinking enough fluid to avoid dehydration.
• No evidence for cranberry products or urine alkalinising agents to treat lower UTI.
• When considering antibiotics, take account of severity of symptoms, risk of complications, previous urine culture and susceptibility results, previous antibiotic use which may have led to resistant bacteria and local antimicrobial resistance data.
• BNF: Nitrofurantoin may be used with caution if eGFR 30-44ml/min to treat uncomplicated lower UTI caused by suspected or proven multidrug resistant bacteria and only if potential benefit outweighs risk.
• Low risk of resistance: younger women with acute UTI and no risk.
• Risk factors for increased resistance include:
➢ care-home resident;
➢ recurrent UTI;
➢ hospitalisation for >7 days in the last 6 months;
➢ unresolving urinary symptoms;
➢ recent travel to a country with increased resistance;
➢ previous UTI resistant to trimethoprim, cephalosporins, or quinolones.
• If risk of resistance: send urine for culture and susceptibilities; safety net.
• <u>Women:</u>
• Treat women with severe/≥3 symptoms.
• Women <65 years (mild/≤2 symptoms): pain relief, and consider back up antibiotic (to use if no improvement in 48 hours or symptoms worsen at any time) or immediate antibiotic
If urine not cloudy, 97% NPV of no UTI.
If urine cloudy, use dipstick to guide treatment: nitrite, leukocytes, blood all negative 76% NPV; nitrite plus blood or leukocytes 92% PPV of UTI.
• <u>Men:</u>
• Immediate antibiotic.
• Men <65 years: consider prostatitis and send MSU, or if symptoms mild or non-specific, use negative dipstick to exclude UTI.
• Nitrofurantoin is not recommended for men with suspected prostate involvement because it is unlikely to reach therapeutic levels in the prostate.
• <u>All patients >65 years</u>: treat if fever >38°C, or 1.5°C above base twice in 12 hours, and >1 other symptom.</td></tr>
<tr><td colspan="3">If treatment failure always perform culture.</td></tr>
<tr><td colspan="3">• Consider alternative diagnoses and follow recommendations in the acute pyelonephritis or acute prostatitis sections, basing antibiotic choice on recent culture and susceptibility results.</td></tr>
<tr><td colspan="3">If first line unsuitable or eGFR <45ml/min & MSU indicates susceptible:</td></tr>
<tr><td>Pivmecillinam

OR

If high resistance risk & MSU indicates susceptible:
Fosfomycin</td><td>400mg STAT then 200mg TDS

3g STAT</td><td>Women: 3 days
Men: 7 days

Single dose</td></tr>
</table>

Please see attached SWL Medicines newsletter:

Key points for Extended Access from this and MHRA updates:

1. Further reminder not to use antibiotics routinely or prophylactically in patients with Covid -19, even when they have risk factors (only use if high index of suspicion of secondary bacterial infection)

2. Another pregabalin alert – risk of respiratory depression particularly in older adults so should be started and up titrated cautiously (I don't think this is a medication we are likely to be starting in the EH clinic setting)

3. Very useful sick day rules for T1 and T2 diabetics affected by Covid. There is a link to them in the summary document and they have very clear guidance on monitoring and which medications to stop or start.

4. Covid vaccine monitoring – has only seen mild reactions - I think this is what we have seen locally.

5. Yellow care monitoring – there is a drive to improve data of adverse reactions to medication in pregnant and breastfeeding patients so please do consider this. This forms part of a wider drive to improve the quality of information available to women to make informed decisions about using medication in pregnancy and breastfeeding

   https://yellowcard.mhra.gov.uk/

Regards,

Richard Hughes