

Antibiotics for acute conjunctivitis

After 16 years of practice, I find it hard to read Visscher and colleagues' recommendations for the treatment of conjunctivitis.¹

For many years I have been treating conjunctivitis with ciprofloxacin eye drops. All of my patients get complete slit lamp examinations. The vast majority are better in 24 hours and return to their normal activities.

To withhold treatment is absurd. The cost of ciprofloxacin eye drops is less than \$10. The risk of an adverse reaction is extremely low. Why would you put the rest of the family at risk for no reason? Also, the child would probably miss several more days of school waiting for the infection to go away on its own, if it does at all.

As a physician who has seen multiple cases of epidemic viral conjunctivitis and bacterial conjunctivitis, the difference between the 2 conditions is obvious, and the different treatments would be started at presentation.

In my opinion, this is yet another example of clinical researchers being out of touch with patients' lives.

—Gary M. Ohashi MD
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Reference

1. Visscher KL, Hutnik CM, Thomas M. Evidence-based treatment of acute infective conjunctivitis. Breaking the cycle of antibiotic prescribing. *Can Fam Physician* 2009;55:1071-5.

Preaching to the choir

With respect, I would suggest that the review of conjunctivitis recently published in *Canadian Family Physician*¹ is only preaching to the choir. The case description actually nailed the real problem on the head: "the boy needs 24 hours of treatment before he can return to school." As both a family physician and a parent, I can tell you that no amount of discussion allowed me to avoid treatment with my own children, owing to mindless, non-evidence-based rules of the local school system, enforced by the school nurse! Perhaps this article should be published in both nursing and education journals to educate those who make up these rules.

—Rick Zabrodski CCFP(EM) FCFP
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Reference

1. Visscher KL, Hutnik CM, Thomas M. Evidence-based treatment of acute infective conjunctivitis. Breaking the cycle of antibiotic prescribing. *Can Fam Physician* 2009;55:1071-5.

Treatment of conjunctivitis

Visscher et al subtitle their excellent paper "Breaking the cycle of antibiotic prescribing."¹ They nevertheless acknowledge that physicians' behaviour is only minimally altered by guidelines and cite several influential external factors affecting antibiotic prescribing, such as parental expectations, school board policies, and lack of patient education materials. I fear that they are too kind. Repeated studies have documented antibiotics being prescribed to

patients diagnosed with common colds in the range of 40% to 50% of cases.²⁻⁴ This behaviour is not the result of lack of education or inappropriate expectations; both the physician and patient know perfectly well that antibiotics are futile. Given that this behaviour is neither rational nor apparently modifiable, I would suggest that a more useful approach is to adopt a "harm reduction" strategy.

The main problems with the inappropriate prescription of topical antibiotics, as noted by Visscher et al, are the development of resistant organisms, possible adverse reactions, and excessive costs. The first can be avoided by using antibiotics that are not used in other settings; the second can be surmounted by judicious selection of antibiotics with a very low rate of sensitization. All 3 criteria can be met by the use of over-the-counter preparations, such as polymyxin-bacitracin (eg, Polysporin). (Neomycin-containing preparations, such as Neosporin, are less desirable, as the neomycin component is quite sensitizing.) Several years ago, when I worked in a hospital that served as the regional eye-care referral centre, I undertook a study (which I never reported) of the culture results obtained over a 3-month period from all eye swabs, from both the emergency department and the ophthalmology clinic. With the notable exception of the genus *Pseudomonas* (which is readily identifiable clinically by the characteristic bright green pus), all organisms cultured were uniformly sensitive to polymyxin-bacitracin. I would suggest that weaning physicians off prescription antibiotic preparations by reassuring them that they can effectively kill any bacteria they might encounter with simple over-the-counter preparations—even if this goal is inappropriate—is likely to be more successful than trying to modify their imperative to prescribe.

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Competing interests

Dr Maxwell has no connection with the makers of Polysporin and no conflicts of interest to declare.

References

1. Visscher KL, Hutnik CM, Thomas M. Evidence-based treatment of acute infective conjunctivitis. Breaking the cycle of antibiotic prescribing. *Can Fam Physician* 2009;55:1071-5.
2. Fischer T, Fischer S, Kochen MM, Hummers-Pradier E. Influence of patient symptoms and physical findings on general practitioners' treatment of respiratory tract infections: a direct observation study. *BMC Fam Pract* 2005;6(1):6.
3. Leblebicioglu H, Cambaz S, Peksen Y, Gunaydin M. Physicians' antibiotic prescribing habits for upper respiratory tract infections in Turkey. *J Chemother* 2002;14(2):181-4.
4. Cantrell R, Young AF, Martin BC. Antibiotic prescribing in ambulatory care settings for adults with colds, upper respiratory tract infections, and bronchitis. *Clin Ther* 2002;24(1):170-82.

Correction

In the article "Treating prediabetes with metformin. Systematic review and meta-analysis," published in the April 2009 issue of *Canadian Family Physician*, an error appeared in the byline. The first author should have been listed as Muriel Lily.

Reference

1. Lilly M, Godwin M. Treating prediabetes with metformin. Systematic review and meta-analysis. *Can Fam Physician* 2009;55:363-9.