

## SELF-CARE WITH SYSTEMIC ANTIBIOTICS IN NEW ZEALAND –WILL DATA HAVE AN IMPACT ELSEWHERE?

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In this issue Natalie Gauld comments on the recent reclassification in New Zealand of trimethoprim for supply by accredited pharmacists to women with uncomplicated lower urinary tract infection<sup>1</sup>. The availability of a 3 day supply of trimethoprim from pharmacies, reflects best practice in the treatment of uncomplicated UTI. However, the Medicines Classification Committee (MCC) implied that this was not always followed by local prescribing general practitioners. This argument, and the counter arguments of the opponents to the switch, are familiar to those of us that followed the public consultation process which accompanied applications for oral trimethoprim and nitrofurantoin to be available as 'P' medicines in the UK. Those applications were withdrawn in the face of opposition from microbiologists and others, who saw the move as likely to lead to increased antibiotic resistance<sup>2</sup>.

The switch of trimethoprim in New Zealand presents, for the first time, an opportunity to study prospectively the effects of increased access to a urinary antibiotic for women with cystitis, on the resistance patterns of pathogens. If the switch is embraced by pharmacists, and if the public is adequately informed of the move, we should be able to establish whether the level of usage of trimethoprim for cystitis does indeed rise. It may be that self-care will simply substitute for some prescriptions, but it is also possible that there is an unmet need which will result in a modest increase in overall trimethoprim usage. It is uncertain what impact, if any, a modest rise in the usage of trimethoprim would have on the susceptibility of pathogens; but this too is amenable to study by surveillance.

Gauld speculates that such data could inform considerations of similar switches elsewhere. However those expecting any reopening of the debate in the UK may be disappointed. In the case of nitrofurantoin, there was substantial evidence, including from countries where that urinary-specific antibiotic represents the first line choice, that substantial differentials in usage between countries did not lead to increased resistance in those countries with most consumption<sup>3</sup>. It is implausible that any increased usage as a result of re-classification would have produced a different result.

In reality, the objections to self-care with systemic antibiotics are principally empirical and political, and therefore not likely to be overcome by more data. For example, it is easy to understand the difficulty of reconciling a proposal to increase access to an antibiotic for self-care, with calls for the public not to expect antibiotics from GPs for most common ailments. On the face of

it, increased access to antibiotics, and better antibiotic stewardship seem incompatible<sup>4</sup>. We also know that unregulated access to antibiotics (including from pharmacies) continues to be a problem in some countries, and that hoarding and subsequent misuse of prescription antibiotics is widespread<sup>5</sup>. Conflation of proposals for regulated self-care with this widespread unregulated and inappropriate self-care is predictable. In 2001 the Council of the European Union (which determines general political guidelines for the EU) issued a recommendation to Member States that they should 'implement control and preventative measures to support the prudent use of antimicrobial agents and contribute to limiting the spread of communicable diseases by: a) restricting systemic antibacterial agents to prescription-only use...'<sup>6</sup>. In the face of such a political position in Europe, even the most compelling evidence-based arguments for limited and regulated self-care with systemic antibiotics are likely to be met with implacable opposition.

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