Letters / Correspondance

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Childhood URTIs

To the Editor:

In response to an article[1] on the treatment of childhood upper respiratory tract infections (URTIs), I have the following comments.

The definition of misuse of antibiotic seems to be based on epidemiological and microbiological data obtained from other studies more than on clinical backgrounds arising from the physical exam and investigations performed in the reported group of pediatric patients — I believe this is a major flaw of the paper.

I am perfectly convinced that some antibiotic prescriptions could have been avoided in consideration of the possible viral etiology of at the least some of the diagnosed acute otitis media (AOM) cases and based on the fact that AOM is not followed by complications and resolves spontaneously. However, I can imagine what made the family physicians more prone to suggest antibiotic treatment in that specific group of patients.

The first query is about the diagnosis. I do imagine that some of the children who were diagnosed with AOM may actually have had a difficult otoscopic exam. Examination with portable otoscope has strong limitations and may be difficult in children. Wax may have been present, and visualization of the inner ear could have been far from perfect. Etiological diagnosis by microbiology is virtually impossible in absence of perforated tympanic membrane (TM) (no distinction between AOM with intact or perforated TM was made in terms of antibiotic prescription pattern in this study), despite some swab being collected from the oro/rhinopharynx in an attempt to isolate the agent that may be eventually responsible for the infection or tympanocentesis and middle ear fluid culture performed.

A clinical/otologic score evaluating severity of TM findings (redness and bulging) and patient's fever, irritability and ear tugging, may be of some help, but it may also be misleading and, anyway, it would not add valuable information in discriminating among various bacterial etiologies of AOM (which equally accounts for inappropriate antibiotics prescribing).

In a rural context it may be complex obtaining a second visit if things should not go as expected. And expectations of the parents are usually quite high. It would be rather interesting to see which percentage of pediatric patients with the diagnosis of AOM that were not prescribed antibiotics did actually receive antibiotic treatment on a second occasion and the rate of complications in this subpopulation. In this context it seems likely that the family doctors could have experienced few problems in supporting their therapeutic approach to the parents and that their prescription pattern did take into account the degree of urgency and magnitude of the problem as perceived by the parents. I believe that more accurate diagnostic tools and otoscopic skills would be extremely helpful in improving the prescribing pattern of family physicians in rural areas as well as urban ones.

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Reference

1. Hamilton S, Graham D. Rural emergency department antibiotic prescription patterns for the treatment of childhood upper respiratory tract infections. *Can J Rural Med* 2003;8(3):185-9.

[One author responds:]

The aim of this study was to present the experience of a single rural emergency department. The bulk of Dr. Cervoni's comments have stressed the importance of physical exam skills leading to diagnosis; however, we would emphasize the multiple studies that have demonstrated that it is virtually impossible to accurately differentiate bacterial and viral URTI etiology clinically. We therefore considered the more important question to be this: Once a diagnosis of a URTI is reached, how do the actual prescribing patterns of Canadian physicians compare to those proposed in current guidelines?

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