Comments for Query: ‘Antibiotic Allergies and Infectious Disease Practice’

Comments made by 119 respondents.

Pediatric responses are shown in blue font and State or province of practice shown, e.g., [CA]

Importance of a Good Allergy History

- I am frequently the only one inquiring about the details of the prior "allergy". [CA]
- 40% of patients self-report B-lactam allergy and little effort is expended to ask additional questions to clarify the validity and nature of the reported allergy. Practitioners simply accept the patient's self-diagnosis and record it in the medical record [NY]
- I'd like to develop a practice metric wherein patients with reported allergies have a healthcare provider actually take the time to discuss it with the patient to determine if vancomycin is really needed. [LA]
- A thorough history is most often omitted, which can be very useful in decision making. [VA]
- The most important role I play is taking (and teaching others how to take) a good history. Countless the number of times the allergy history proves to be nausea or a yeast infection or a family member with an allergy. [GA]
- History taking and look at the medical record for the past history. EMR is most useful for getting previous history of drug administration. [FL]
- Infectious Disease physicians are often the doctor that dispels incorrect allergies listed in a patient's records by careful and specific questioning. [CA, OH]
- My answer to Q#3 is to inquire about history of taking cephalosporins and switch if applicable. [MO]
- Just talking to patients about the allergy many times is more useful than skin tests [ND]
- We see a lot of overuse of drugs such as vancomycin, aztreonam because providers do not take the time in my opinion to tease out the historic details of many drug "allergies" [ME]
- Pharmacists and nurses should also be involved and be able to take better histories, often never inquiring what the reported allergy was. Patients complain of upset stomach, headache and get labeled as PCN allergic for the rest of their lives, often leading to the use of broad spectrum and extremely expensive alternative agents [NJ]
- A good reliable history from the patient or family is very helpful, and we are many times the only ones to take a careful history [IN]
- When dealing with antibiotic allergies, history is the least expensive and probably a very cost effective way to formulate recommendations. Most physicians (non-ID) do not take an appropriate history and use more unnecessary agents. I believe the ID physician would provide valuable recommendations in this setting as well as very useful recommendations in patients with serious drug allergies. I believe ID physicians should have a solid pharmacologic base prior to prescribing any antibiotic! [FL]
- Importance of a physician taking detailed allergy history is key. Many times a nurse or triage person enters whatever the patient says into the medical record without evaluating the patient fully for likelihood of true allergic event. [NC]
• Education of primary care providers to document as extensively as possible the allergy: agent, age when occurred, setting/illness, manifestations. I find that many patients carry an "allergy" in their chart with just the name of the drug or drug class without further thought. Fleshing this out would result in fewer referrals for antibiotic management. [MD]

Availability of and Barriers to allergy testing
• Our allergist doesn't think penicillin skin testing provides useful information [IN]
• Even if the tests were reliable, one impediment to testing is the time required to do the testing and interpreting the results in the setting of little reimbursement and potential liability when there are several alternative drugs available. [MS]
• Allergists no longer come to our hospitals; the 'immunologists', mostly either pathologists or rheumatologists, do not do allergy testing. Some testing is available, after a wait to get seen, by outpatient allergists. I think testing would be a useful adjunct to the practice, if it was not too labor intensive and reimbursed commensurate with the time and risk.... Probably should be part of ID training, given the scarcity of allergists willing to do inpatient work. [NM]
• Re Q8 about skin testing before elective surgery - I am unsure we could get as many tests as would be needed [CO]
• Intermittent availability of allergist [NY]
• We have outpatient skin testing available but not available for inpatient [MA]
• While of course we periodically get asked about a "substitute" for an antibiotic when a child reportedly has a drug allergy, peds ID here typically lets Allergy/Immunology and Pediatric Pharmacy deal with most of the questions you have asked. [GA]
• In general, skin testing supply has been low, and only in dire situations will we try to use [TX]
• Would love to have PharmD or Np/PA trained to do this w/ appropriate reimbursement. Our PICU attendings are willing to have this done - on their floor! [MD]
• As a pediatrician and w/ hospital based practice: most of these issues come up in the PICU, where observation is good. Use allergist for skin testing, however, not always available /NC]
• We do have penicillin skin testing available at the Allergy & Immunology Clinic but availability is limited by staffing and so appointments are usually weeks after the order is placed, and they are not able to offer this service in the hospital at this time. When we have to give a beta-lactam to a patient with a reported allergy, what we usually do is desensitize without skin testing. [AZ]
• We do have at least one allergist in the community who is able to perform PCN skin testing, but it generally requires an outpatient referral and thus is entirely useless when dealing with a hospitalized patient [OR]
• Allergy testing /desensitization available on fee basis when not available in house [TN]
• We have just adopted the penicillin skin test at our facility and we are working to use it preoperatively in patients with reported allergy. Currently, vancomycin is used for anyone who reports allergy to beta-lactams but this may change soon. [CO]
• Outpatient allergy testing only by Allergy /SC]
• We have an allergist, but they are not terribly accessible. The numbers and types of alternative treatments, even in the setting of a purported allergy, make allergy testing too labor intensive in a cost/benefit risk/benefit analysis. [PA]
• Most significant barriers to penicillin allergy testing are longstanding non availability of standardized test and frequent statement by allergist of non-generalizability to other beta lactam antibiotics [PA]
• From personal experience, I was able to push our pharmacists to get trained and start testing for PCN allergies when indicated. The main resistance was in fact from the Allergist who had recommended that only MDs should be allowed to perform and interpret the test. The PCN testing process is cumbersome and can be limited especially in the presence of other meds used routinely in the
hospitalized patient that may affect the result or even preclude from testing. A better and easier test needs to be produced for more practical deployment of such an approach. [IA]

- Over the last year, we have an allergy service. They are not always around. We use extensively for serious infections. For the not so serious, we waffle—we look for evidence patients have received cephalosporins or for a PCN rash that doesn’t sound like angioedema, urticaria and just give cephalosporins. We have done a lot of skin testing for serious "allergies"; no one has had a positive skin tests. The pts all tolerate beta lactams. [MA]

Comments on allergy testing and the role of the ID physician

- 1. We (ID) are definitely the default option. 2. Common source of consults. [NC]
- Not a major issue [MI]
- This is a HUGE problem! [OH]
- Terrific survey since this is clearly within our scope of responsibilities. [NY]
- Almost always alternative drugs are available for the small number of patients who have true recent severe allergies. ID docs role is to understand whether testing is needed or not and to understand true risks based on past history [AR]
- This is a big problem. We cannot get allergy consults. [CO]
- Very important. Thank you. A tremendous misinterpretation of allergies usually. [LA]
- We developed a certification in skin testing with the help of an allergist at our academic affiliate, but finding time to do the program is an issue for ID docs. This should be incorporated into ID fellowship so we can all be trained. [NM]
- I have used penicillin desensitization in patients allergic to penicillin. I perceive allergy testing as cumbersome and there are usually other options for treatment that I can use. [SC]
- We are very fortunate to have allergists at our institution to perform allergy testing at our request. I think that their services are underutilized. They have certainly helped us in managing a number of very complicated patients with the appropriate antibiotics by testing the patients and giving us clearance to use the medications. Although ID is frequently consulted for this issue, we refer them to our allergists who can perform the appropriate tests and give us desensitization protocols as necessary. [FL]
- ID Physician can offer other alternatives (e.g. daptomycin) and address the need for uses of specific medications. [CA]
- Currently our role is not clear! [CA]
- We deal with a lot of drug allergies! It would be great to feel more comfortable in dealing with them.

Issue of Allergies versus intolerances

- Most "allergies" are intolerances [MA]
- We see parents who report their child is allergic to penicillin because others in the family are. Patients/caregivers report allergy when a patient develops diarrhea. [NJ]
- Most patients who give a history of "penicillin allergy" when tested are not truly allergic. [TX]
- To my mind, anaphylaxis is the only absolute contraindication to giving a med, keeping in mind the 'rash' is often from a concurrent infection and not the antibiotic. We also have an issue in pediatrics of behavioral problems, especially if a child 'vomits' medications and this becomes 'an allergy'; sometimes a bit difficult to tease out. [NC]
- Exceedingly common for chart to list an allergy to a drug which simply caused a side effect such as nausea or diarrhea. I try to correct the records. [OH]
- The vast majority of these "allergies" are not accurate and in 23 years of ID practice I have never had a problem using cephalosporins with hx of rash to penicillin [WY]
• I think that one of the key questions that I ask patients with a hx of Pen allergy, which is rarely asked by others, is "Have you taken amoxicillin since?" It's amazing how often the answer is Yes, and they've had no problems with it. [WA]

• I always check previous records in our computer and ask Pharmacy to see if pt has received a cephalosporin in past few years. Occ a PCN allergy pt gets an Ancef dose for elective surgery and if tolerated then we are "good to go". [CA]

• I agree that most patients with remote hx of non-anaphylactic pen allergy can be treated w/ ceps/pens

• It seems like more than half of reported "allergies" are bogus. [WA]

• Many times reported allergies by patients turn out to be insignificant when they are challenged by the drug. [DE]

• More than 75% of time PCN allergy is due to side effects like vaginitis, nausea, “my parents are allergic so I am allergic". I always try cephalosporin and Primaxin; have never had problem in 20 years of practice. ONLY "my throat chokes with PCN" is a real allergy to PCN. [NY]

• We treat anaphylaxis differently from skin rash in our practice [SC]

• I generally disregard any history with juvenile reaction to antibiotics. I give cephalosporin and Primaxin; have never had problem in 20 years of practice. ONLY "my throat chokes with PCN" is a real allergy to PCN. [MN]

• It is important to be sure about the nature of allergy. Patient description as if penicillin allergy has been found will result in loss of a major class of antibiotics. [MB]

Clinical management of penicillin, beta lactam and sulfa allergies

• I think we need to educate non ID physicians on how to interpret allergies...the difference between a delayed sensitivity and IgE mediated; and how cross sensitivities work. They are often the ones on the front line who just see PCN allergy, make no attempt to find out more about it and avoid the entire class when that might not always be necessary. [LA]

• For question # 2, the case with PCP and sulfa allergy, I would consider giving TPM/sulfa without desensitization if corticosteroids were also being given for PCP. Our experience is that, under the cover of steroids, the sulfa is typically tolerated. [GA]

• Cefazolin is certainly safe but I don't worry about oxacillin either. Not all Beta lactams are the same.

• If ambiguous for anaphylaxis risk, we use oral PCN desensitization protocol. Finding inadvertent receipt of a preop dose of Ancef (etc) gets us off the hook a LOT! (Takes time, though) [NC]

• If we didn't know and have to give a B-lactam, we load the pt with Benadryl and hydrocortisone then start with a very dilute IV dose of the B-lactam and gradually increase dose over time at 10-15 minute intervals to full dose of the med. [NV]

• Unless it is an anaphylaxis history a therapeutic trial works well [NY]

• Primum non nocere [OK]

• I would be interested in knowing how often beta lactam skin testing is done by other ID physicians. The immunologists do not like coming to the hospital so I don't usually force them to come in. Another question is how many ID docs desensitize for beta lactams if there is a concerning history and we have no good alternatives. Eg desensitizing for ampicillin in a patients who has enterococcal endocarditis and has a concerning allergy. [CA]

• I presume that when you write "beta-lactam", you mean "a penicillin", not "a penicillin or cephalosporin". The answers differ based on the specific antibiotic involved. [PA]

• We routinely use meropenem for patients with pen allergy, based on this article: J Chemother. 2008 Apr;20(2):233-7 [NJ]

• Unfortunately an area where style and past experiences outweigh science [MS]

• Ongoing controversy fueled by little data. The review by Pichichero in Family Practice vol 55 No 2 February 2006 pp 106-112 is the best that I am aware of and makes the most sense. [CA]
• I use cephalosporins or carbapenems for penicillin allergic patients who do not have a history of anaphylaxis and have not had a problem in 25 years of ID practice. We do not do skin testing except in very rare circumstances (syphilis in pregnancy with a history of severe PCN allergy). [OH]
• In patients with multiples allergies, we should suspect the possibility of an autoimmune disorder [PR]
• Should take into account that only 3-5% of patients with allergic rxn to a pcn will react to cephalosporin and probably vice versa. [MN]
• Patients’ ability to tolerate a risk of adverse drug effect is very key in my assessment of risk assessment
• We sometimes move straight to desensitization to oxacillin in patients with hx PCN allergy who have a severe MSSA infection. [NY]
• We can learn a great deal from cystic fibrosis providers, who deal with these problems on a daily basis
• Have not kept up with status of availability of minor/major determinant reagents. If they are available and accurate we should disseminate the info to decrease slide of alternative agents [CA]
• I treat all pts with history of PCN allergy with carbapenems if broad coverage indicated and cephalosporins if MSSA isolated. Have only had one pt develop allergy to carbapenems after 30 days of treatment. [NC]
• re #2 - we don't have a formal desensitization protocol. Might prescribe TMP/SMX depending on severity of rash and how reliable the hx was. [MO]
• I basically decide on challenging patients who have a history of beta lactam allergy and I rarely ever use skin testing. I have used skin testing in pts with neurosyphilis and h/o PCN allergy. [GA]
• I don’t treat adults, so I didn’t answer questions 1 and 2. However, if the #1 pt was severely ill and had a questionable hx of rash with t/s, I would rx with t/s. [TX]
• I often tell the residents that what better place to "test" the reported remote, long labelled "allergy" than in the hospital setting. I am less cavalier about TmPSmX than beta lactam history. [MI]

Need for IDSA guidelines/review
• I think a formal IDSA guideline would be useful to share with my hospital-based colleagues (most ID people I know already know this information). Giving the information to patients is the least useful, and the online training course would have low attendance from the people who are most in need of the education. [CA]
• Please make / we need IDSA guidelines!! [CA, TX]
• This is a good topic for an infectious-diseases oriented review! [UT]
• UpToDate has nicely translated Joint Task force practice parameter for use of cephalosporins, carbapenems, monobactams in pcn-allergic pts. We frequently use this algorithm to give cephalosporins (without skin testing) to patients with non-anaphylactic history of penicillin allergy more than 10 years ago, which is what I would do in vignette #3 above. Because we did not have major determinant penicilloyl-polylysine (Prepen) available from about 2004-2009, penicillin skin testing was not as reliable, and I rarely did it, and did more graded challenge, and some desensitization (induction of drug tolerance in the newer terminology). I am also an allergist and would be happy to work on guidelines or whatever. [CA]
• For those who don't have ready access to allergists to oversee skin testing and desensitization, protocols for desensitization may be useful. Guidelines that outline when it's safe to proceed w/ use of beta-lactams or when to use desensitization to sulfa with a history of allergy could be useful. [IA]
• This is always a concern and will be good to have a flow diagram with guidelines [NE]
• Desensitization protocols very helpful in managing patients who are stated allergic to the drug of choice.
• The real education needed is for other physicians, not patients. [CA]
• Guidelines are helpful but obviously there needs to be an individualized approach. Allergy testing would be very helpful in my opinion. [OH]
• Desensitization protocols aside from the one in the Sanford guide [IL]
EMR documentation issues

- EMR "alerts" make the problem of using antibiotics more difficult e.g. PCN allergy patients generate an alert warning against the use of aztreonam with our electronic health record. [IN]
- Need better choices for documentation in our EMR of allergies [OR]
- Most allergy lists in EHR by RN and pharmacists useless & almost harmful. [MA]
- As an ID doc, "discontinuing" antibiotic allergy is an important function. [NY]

Pediatric-specific issues and comments

- I'm a pediatrician. Lots of mothers say that their children 'got a rash' when they took the pink medicine. I usually give a beta-lactam anyway. Also, new CDC Guidelines for GBS prophylaxis at delivery recommend beta-lactams even if the pregnant woman has a history of hives with a beta-lactam. So far, no anaphylaxis! [CA]
- I am a pediatrician, and the way I would answer some of the questions was not an option. [MO, AL]
- We are trying to bring the ALK Penicillin allergy skin testing to the hospital. Issues have to do with policies and responsibilities, but in pediatrics it will be very useful as we have more limited therapeutic options. [FL]
- Please include pediatric examples and include another factor for consideration: parental recall when they have multiple children. [OR]
- Including PedsID physicians in the survey design may have carved out specific pediatric issues; e.g. common differential diagnosis for us is concomitant viral infection when an exanthema arises. [IA]
- Less of an issue in pediatrics. [AL]
- Is more complex in pediatric ID as further limitations of available agents (suspension forms, FQ use etc....). Recent shortages of agents have also played a role. [MB]

Issues related to antibiotic stewardship

- Aztreonam costs $200/day (2gm IV q8h) [WI]
- Many patients are already on antibiotic chosen by House Staff: I will reduce from a broad spectrum antibiotic, but continue with vanco or daptos or cephalosporin, if doing well [VT]
- Daptomycin is my preferred agent. It has nothing to do with mild allergy. [ID]

Other Comments

- 1. This is a good questionnaire. Legal concerns continue to dominate this field. [IL]
- Advice from a now departed old-timer: "Fake a skin test and give it anyway." [LA]
- I often give a drug based perceived risk and inform the patient about the advantages to knowing what drugs might be useful [MD]
- Is the reference in #10 above available without needing to subscribe to that journal? [NH]
- Pharmacists are crazy when we want to use B-lactams on a pt with PCN allergy. It is usually not worth it to fight - takes too long [CA]