Comments for Query: ‘Antimicrobial Drug Shortages’

Comments made by 93 respondents

[Pediatric responses are shown in blue font]

Comments about Specific Cases/Examples of Drugs Affected

• [Instead of] IV Bactrim, an AIDS patient was given po instead; he died from severe PJP, but he had horrific prognosis and IV Bactrim would not have saved his life [CA]
• It is a mess - caused one MAI patient serious deterioration [CA]
• IV Decadron used only on initial bacterial meningitis situation. Oral TMP/SMX provided for IV. Rounding aminoglycoside doses to not waste drug. [NC]
• We've used quite a bit of PO Bactrim because of its excellent bioavailability [NY]
• Most affected are patients who need high dose co-trimoxazole, in my recent experience [TX]
• Cefixime was short for a while - used quinolones for GC despite possible resistance [IL]
• Had to use po Bactrim instead of IV for PCP - longer stay. Other drugs not available: meropenem, raltegravir in the hospital, nitazoxanide po, Flagyl po [TN]
• Amikacin, Bactrim, aztreonam & oral Tamiflu -- all >20 patients have been adversely affected by the shortage of each [MD]
• We have used oral Bactrim in high dose for moderately ill PCP patients; we have used various dosing regimens of cidofovir instead of foscarnet; our nursery was told to use cefotaxime instead of gentamicin [NJ]
• We currently replaced gentamicin with tobramycin and stopping antibiotics after 48 hours of negative cultures in neonates [OH]
• Aztreonam has been the biggest problem for me in past 2 years, =>much broader rx [MD]
• We are lucky to have a purchaser who seems to be ahead of shortages, so we have had limited impact. One incident I'm aware of involved amikacin which was not given to the patient, who fortunately did ok. Use of amikacin is limited here. There was one other patient who needed IV TMP/SMX - though we were afraid we would run out before she could transition to oral, that did not happen. [AZ]
• With foscarnet unavailable for our bone marrow transplant patients, we have been forced to use ganciclovir with significant concern for marrow toxicity resulting in what could be considered a more reasonable threshold for management of CMV antigenemia [TX]
• We have had to change therapy for some serious PCP cases; at least one died, though I can't be certain it was due to lack of IV TMP-SMX. Also altering Rx for MOTT and some serious nosocomial infections due to amikacin shortages. [FL]
• Foscarnet procured from Europe, as shortage of this drug is an ongoing issue. Alternative was to use cidofovir in appropriate setting vs. ganciclovir. This is in the setting of BMT patients with opportunistic viral infections. [CA]
• For Nocardia brain abscess, I could not use IV Bactrim; I used IV imipenem and amikacin (only for few weeks). Luckily I was able to get the sensitivity and could use ceftriaxone since the culture was resistant to imipenem. For resistant MDR Pseudomonas, using colistin IV. [MI]
• In the absence of IV SMX-TMP, I have used the oral formulation [OR]
• Needed to use oral Bactrim for Pneumocystis in 2 critically patients. Not sure they absorbed it well and failed treatment. Needed to use IV pentamidine and clindamycin/primaquine instead [PA]
• For severe PCP, gave clindamycin with primaquine instead of Bactrim. For pulmonary nocardiosis, used imipenem instead of amikacin. [DE]
• We have had to treat several HIV patients with PCP using oral Bactrim due to IV shortages. Luckily all have thus far been able to tolerate PO well enough to complete therapy. [TN]
• We used tigecycline as a second drug (instead of amikacin) along with colistin for a couple of patients with carbapenem-resistant gram-negative bacteremias. Tigecycline is generally useless for treating actual infections. One story: a patient who had severe gut GVHD could not take oral TMP/SMX and we could not give it IV, so he ended up developing PCP. [MD]
• Regarding IV Bactrim, we proceeded with po and monitored serum levels. [GA]
• In most patients could use enteral rather than IV TMS. Biggest problems have been with MDR TB patients when none of the injectables were available and with MDR gram negatives with no alternatives other than amikacin. On the plus side, shortages of some agents used by our surgeons for irrigation has enabled us to curtail use of these irrigations. [NJ]
• Use of colistin increased related to amikacin shortage; use of Bactrim PO increased as IV use very restricted [OH]

Suggestions for Addressing the Overall Shortages Issue
• I think this should be an issue for IDSA, and have suggested it previously. When there is limited profit in these older agents, there is little impetus for multiple producers to make agents or for money to be spent fixing problems or improving production. [CA]
• 1. Improve supply of raw drug; 2. Improve quality control to avoid FDA shutdown of manufacturing; 3. Keep manufacturing "at home". [FL]
• I think this is an issue that IDSA should monitor and be proactive about. The pharmacy at my hospital has been very active in helping to obtain amikacin for my MDR TB patients, but that is a need that I know about in advance. These issues usually come up with acutely ill patients. [CA]
• Network of high frequency users, such as major referral centers, should be given access to limited supplies with criteria for triage [FL]
• We need to develop a list of vital drugs and stockpile [IN]
• Once a shortage is foreseeable, allocating drugs across the US so the last of these drugs can be conserved and used more judiciously and saved for those pts that really need it. With better advanced notice we can plan for the shortage rather than being completely out from one day to the next. [LA]
• The VA model is a good one. Others may benefit from its process. [SC]
• Guideline of alternative or timing of when it should be available should be announced through IDSA, or EIN or CDC web base [NV]
• An organization to recommend alternative therapy - one site. [PA]
• FDA should require companies to notify them of shortages the minute they occur so alternatives can be sought. [WI]
• The government needs to assure there is more than one supplier of key drugs [IN]
• We should be provided with a list of shortages and also alternatives; it is extremely time consuming for the clinicians to look at alternatives. There should also be a "compassionate use" website where we could get a short supply of the drug. Communication w/ other area hospitals that have a surplus of the same drug or are willing to share/ sell a small supply is important and a pharmacy/ ID network should develop it. The FDA website is not very user friendly and sometimes inaccurate. We have a clinical pharmacist on a daily basis tracking shortages of all classes of drugs (time consuming and deviating her from direct patient care due to short staffing). [FL]
• This is a huge problem that needs more public attention to put pressure on FDA, professional societies and others to resolve. I see the problem getting worse and not much being done about it. [GA]
• We need urgent guidelines on how to treat specific condition when the drug of choice is not available.
• Industry/FDA should take more initiative in trying to foresee shortages and make plans [CT]
• It would be nice to have third party involved before shortage becomes profound and start regulating nationwide usage before supply gets critically low. Something like national antibiotic stewardship for antibiotics that are at risk of not being supplied. [PA]
• I work at an academic medical center where these issues are communicated very well to the inpatient ID consultation team by our excellent ID pharmacists. Where perhaps communication COULD be improved would be if we could receive knowledge months in advance of anticipated drug shortfalls from antimicrobial drug manufacturers themselves. It seems as if we hear about these things from the media, first. If there were some sort of earlier warning system directly to hospitals/academic centers/ or to the CDC, this would potentially be of help by allowing implementation of better prevention techniques, where relevant to disease control. [WA]
• Inter-hospital pharmacy communication to collaborate with accession to needed antimicrobial if possible. Sometimes off-label use of antibiotics in place of unavailable ones. [FL]

Comments about Antimicrobial Stewardship
• Began an Antimicrobial Stewardship Program last year at my hospital and am dismayed at how much effort has been needed to help with these shortages in the hospital setting. No one is happy when you tell them that their "drug of choice" for a specific illness is not available. Sad to see that not only do we not have new antimicrobial drug development, but we are losing some of our old tried and true antimicrobials way too often. [FL]
• Antibiotic stewardship has helped immensely in reducing need. [AZ]
• It is remarkable how fragile the supply chain has become. Chemotherapy drugs have been heavily impacted, as well as things as mundane as D50 and neostigmine (a critical anesthesia reversal agent). While some of the antibiotic shortages have been harmful, I have noticed that a lot of the requests for some drugs are totally unnecessary, and the shortage provides an opportunity for antimicrobial stewardship (not that this is my preferred approach). [CA]
• The recent aztreonam shortage made it clear how over used this medication is in regular practice. [NY]
• This is complicated by the fact that drug wholesalers MAY indeed have stocked up on some of the medications that are in national short supply, thus "protecting" us from these shortages... at least for some time. Clearly, these shortages require a considerable amount of time & effort on the part of pharmacists and hospital personnel, forcing them to scramble to find solutions to these problems rather than focus on typical, critical active patient care issues. In any event, I think this is an area of great importance, and clearly a better system is needed. [WA]
• Stewardship nationwide. Antibiotics only prescribed when needed [NY]
• I have seen several patients in the LTACH setting transferred from acute care for long courses of meds including those in shortage. They are sometimes seen by other ID specialists in those settings. The indication(s) for usage of the agents are often dubious (ie. treating colonization of a wound bed or cath urine specimen), and when there is a good indication it's not clear any thought was given about the possibility that the receiving facility may not be able to obtain the med in short supply. [TX]

Hospital-based Efforts to Manage Shortages
• We learn about each in a timely manner and develop institutional plans for dealing with the shortage.
• Not all shortages affect real-time inventory. Often our pharmacy has supplies of shortage items b/c of active and effective shortages monitoring. Good planning has reduced the immediacy of some shortages. [WI]
• Our pharmacy can often find them somewhere because what we see as an absence is often rationed supply when there is a known shortage [BC]
• We are lucky, in that we have a very good ID pharmacist who keeps us updated about shortages. [WA]
• We have to be creative and also be upfront with the patients/families if we know that the alternate medication has either reduced efficacy or increased toxicity. [UT]
• Upon notice, we perform an immediate inventory with a projection of how long our supply will last based on past usage. We then develop specific criteria for use of the drug in short supply. Based on the anticipated severity and duration of the shortage, the recommendations may be a "soft" warning to a "hard" requirement for an ID consult before the drug is allowed to be used. [TN]
• Even though Bactrim was not available, we were able to obtain it directly from the manufacturer through a special shortage request form. [SC]
• Our clinical pharmacists are proactive in keeping me abreast of outages projected and their resolution for agents I use [WA]
• In our hospital, antibiotics in short supply require approval by an ID specialist to be dispensed. [FL]
• We have altered some of our PowerPlans to avoid using agents in short supply, i.e. use tobra instead of amikacin [GA]

Comments about the System and Shortages
• Not looking good - more MDR pathogens. We need a better system [MI]
• It would seem that money is driving a lot of the shortages. The pharmaceutical industry would prefer to manufacture more expensive agents. [DC]
• This is a growing problem for our system, and it is not restricted to antimicrobials. Shortages of norepinephrine and certain chemotherapy agents have also created difficulties for our patients. [TX]
• Communication about shortages does not fix or even address the problem. The shortages need to be fixed. We are drowning in highly MDR gram negative species. We need amikacin and Bactrim quickly. [NJ]
• It appears that if it is a generic drug, the manufacturers are just not motivated. We have not had amikacin for ~6 months. [NY]
• This is not new. Been dealing with for over 15 years starting with the IVIG shortages. [AR]
• "Pseudo"-shortages occur where our pharmacy will report the product is unavailable, when in reality they did not realize that they were getting faulty information (e.g. being informed that INH was not available as it was "no longer being produced"). Shortages, at least in the past, appear to have hit some regions of the US hard while our own seemed unaffected. Have received some notices of "shortages" on the same day as a notice that the shortage had been resolved two weeks earlier. [CA]
• It seems more common lately and it is frightening and affecting care. [AZ]
• Our system of manufacture, distribution and sales of generic drugs is scandalous! [TX]
• Something should be done to prevent these shortages -- they're becoming all-too-common. [AZ]
• Could not recall any time period in the past when shortages were as frequent or severe [NJ]
• I understand that shortages can and will happen, but in cases like amikacin these shortages should not last for as extended a period of time as they do. [SC]

Need for Additional Information
• Shortage should list indications and options for replacement [CA]
• I'd like better explanation from the FDA about the cause of shortages. Is it really because of higher purity standards? Have problems arisen from prior standards? [IL]
• In many instances, drugs become unavailable without explanation and without any information as to when they may become available again. There should be some notification process for this. [FL]
• I wonder why these are happening? and how to prevent it? [AL]
• I'd like to know what's behind the shortages. [WA]
• We need to make sure that we're notified of this! [WI]
• would like info about WHY shortages have occurred (i.e., contaminated batch of vaccine vs inadequate raw ingredients) [MA]
• Pharmaceutical companies must provide more information as to why shortages are occurring, and a clear timeline for resolution. What accounts for the significant increase in drug shortages? [MN]

Other Comments
• Where a sensitivity report is available on the purported organism, or where predictable sensitivity is available/known for agents not tested, then the choice is often closer and not difficult. For CNS syphilis, other Rx's (no PCN) are less reliable. [MS]
• It has been helpful for the EIN to publish alternative ways to obtain amikacin [OH]
• Unfortunately, these shortages are not like vaccine shortages where you can use a reminder f/u to reinstate usage. If you need these drugs, such as Tamiflu suspension for kids, you need to think of new ways to use what you do have, or use an acceptable alternative (if one exists). [GA]
• I subscribe to the FDA notifications, which has helped me stay current. [NJ]
• I follow suggestions made by EIN. [NC]
• My group of 3 pedi ID's here seems to concur that we have not had to modify since the late summer 2009 erythromycin ophthalmic shortage. [MI]
• I agree about cost increase due to shortages; it is hard to document adverse pt outcomes. [VA]
• Communicating with reps on these issues is difficult because they will not tell you what the real situation is. We are also experiencing disruptions in other products needed for sterilization and disinfection such as sterile gel and liners for sterilizing containers, so there are more potential impacts. [NM]
• There is an app for that. [MI]
• It was helpful to know contact info on obtaining drugs for pharmacist. [NE]
• The majority of the time I have been able to get the drug in short supply when needed. [GA]
• There are functional shortages when the problem is in the distribution network/wholesaler network that have the same end result, but are not felt more broadly when the shortage is for the reasons you outlined above. [RI]
• Lucky not to absolutely need them during the time of shortage. [PR]
• No shortage at this point. We had some shortage of amikacin and intravenous formulation of TMP-SMX a while ago, but there was no impact on patient management as far as I know. [PA]