10 WAYS TO REDUCE FQ PRESCRIBING IN AMBULATORY CARE

1. **Always take a good allergy history.** Document and update antibiotics allergy histories including reactions and timing in detail, especially penicillin and cephalosporin allergies.

2. **For an empiric indication**, before prescribing FQ, stop and re-evaluate. There is likely a preferred agent with a less-severe toxicity profile. (See Chart 2 for recommended antibiotics for empiric use in place of FQs.)

3. **For acute sinusitis or acute bronchitis,** do not prescribe FQ. For sinusitis, avoid antibiotics if at all possible due to high likelihood of viral etiology. For acute bronchitis, antibiotics are not indicated. The FDA specifically warned against use of FQ for these indications in May 2016.

4. **For Community-Acquired Pneumonia, use beta-lactams and/or macrolides when possible;** prescribe high-dose amoxicillin or amoxicillin/clavulanate PLUS a macrolide or doxycycline as standard therapy.
    - Exception: for serious beta-lactam allergy, **levofloxacin** is recommended.

5. **For asymptomatic bacteriuria,** do not prescribe antibiotics. Do not collect urine samples in asymptomatic patients.

6. **For empiric therapy of UTI, recommended treatment for UTI** is cephalexin, nitrofurantoin, or TMP-SMX. The FDA specifically warned against use of FQ for these indications in May 2016.
    - **For uncomplicated pyelonephritis (young non-pregnant females)**, TMP-SMZ or cephalexin are potential options.

7. **For empiric therapy of diverticulitis**, prescribe po cefuroxime plus metronidazole, amoxicillin-clavulanate, or consider hydration with observation for mild cases.

8. **Avoid prescribing antibiotics for asthma or COPD exacerbations.** If antibiotics determined to be necessary for COPD, prescribe a macrolide or doxycycline instead. Antibiotics are generally not indicated for asthma exacerbations.

9. **Reserve directed FQ use (when a patient's microbiologic data documents FQ susceptibility)** for those indications in which no appropriate alternatives are available; this restriction is particularly true for patients with identified higher relative risk of FQ toxicity.

10. **FQ therapy should rarely be used empirically**. If a FQ must be used empirically discuss the potential serious side effects with the patient. Ensure that the shortest appropriate duration for the suspected infection is used.

Table 2. Recommended Outpatient Antibiotics for Empiric Antibiotic in Place of Fluoroquinolone (adapted from asp.nm.org)

Indication	First-line alternative	Second-line alternative(s)
Asthma exacerbation	Antibiotics not indicated	--
Asymptomatic Bacteriuria	Antibiotics not indicated	See uncomplicated cystitis
Bite wound/cellulitis	Amoxicillin-clavulanate	Cefuroxime plus metronidazole Doxycycline plus metronidazole TMP-SMZ plus metronidazole
Bronchitis, acute	Antibiotics not indicated	--
COPD exacerbation	No antibiotics recommended for most cases (high incidence of viral infection or other causes)	Azithromycin Doxycycline
Cystitis, uncomplicated	Cephalexin Nitrofurantoin (if CrCl > 30mL/min)	TMP-SMZ
Diverticulitis, community-acquired	Cefuroxime + metronidazole	Amoxicillin-clavulanate TMP-SMZ plus metronidazole
Pneumonia, community-acquired	Macrolide alone (if atypical infection suspected) or High-Dose Amoxicillin plus macrolide	Doxycycline alone (if atypical infection suspected) High-Dose Amoxicillin-clavulanate plus macrolide
Pyelonephritis, uncomplicated	TMP-SMZ	cephalexin 500mg four times a day.
Sinusitis, acute	No antibiotics recommended for most cases (high incidence of viral infection)	Amoxicillin/clavulanate Doxycycline

TMP-SMZ: trimethoprim-sulfamethoxazole (Bactrim)