TOP TIPS FROM FAMILY PRACTICE

Measles, Allergies, Gout, Flu

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EXPERTS WARN MEASLES COULD BECOME ENDEMIC

Five years ago, health experts declared measles had been eliminated from the United States, thanks to an ambitious measles-mumps-rubella (MMR) vaccination program for children.[1] But as vaccination rates decline, measles is making a comeback. As of mid-August, the Centers for Disease Control and Prevention (CDC) noted 1,356 reported cases of measles in the nation this year.[2]

Now, a study from Stanford suggests measles could become endemic again[3] because measles is so contagious — one of the most infectious diseases in the world. Estimates show that someone with measles will infect 12-18 others, on average. By comparison, someone with COVID-19 can infect about three people, on average.

The CDC recommends two doses of MMR vaccine for children, starting with a first dose at 12-15 months of age and a second dose at 4-6 years of age. In areas near a measles outbreak, however, babies may be able to get vaccinated as early as 6 months of age.

Some adults may need to get vaccinated too. Adults are generally considered fully vaccinated if they received two doses of MMR or MMRV. If born before 1957, they are presumed to be immune due to widespread measles exposure during that time. If a patient received the inactivated measles vaccine between 1963 and 1967, however, they may need a booster and may seek consultation.

FDA ISSUES CETIRIZINE/LEVOCETIRIZINE WITHDRAWAL SYNDROME WARNING

The Food and Drug Administration (FDA) issued a Drug Safety Communication requiring new warnings about the rare but severe pruritus that can occur when patients discontinue the oral allergy medications cetirizine (Zyrtec®) or levocetirizine (Xyzal®) after long-term use.[4] Both medications are second-generation antihistamines approved for treating seasonal rhinitis, perennial allergic rhinitis, and chronic idiopathic urticaria. The median time to onset of pruritus after medication discontinuation was 2 days, with a range of 1-5 days. In 92% of cases where usage duration was reported, patients had used the medications for more than three months before experiencing withdrawal symptoms.

Of the 93 cases where patients reported attempting to restart and stop the medication(s), pruritus occurred in 92. However, restarting the medication(s) resolved symptoms in 71 of 79 individuals (90%), and tapering after restarting resolved symptoms in 9 of 24 patients who attempted this approach. Data suggest that longer medication use may increase the risk of a discontinuation reaction, as "the number of pruritic cases increases with duration of use."

For health care professionals, the FDA recommends discussing discontinuation risks with patients — especially those planning to take these medications long term — and encouraging patients to report severe itching after stopping.

FIVE THINGS TO KNOW WHEN TREATING GOUT[5]

The following are recommendations for clinicians treating patients with gout:

1. It's possible that a patient may have some kidney damage from taking anti-inflammatory medications. Thus, for an acute attack of gout, consider that many rheumatologists use prednisone as a first-line treatment.
2. If prescribing prednisone, start with 40 mg/d for four days, then taper down to 30 mg/d for four days, 20 mg/d for four days, and continue to reduce in that fashion.
3. Clinicians should not start patients on allopurinol during an acute attack — allopurinol does not treat acute attacks. It is helpful in lowering uric acid levels in the blood, and is useful for prevention and management, but patients should start allopurinol after an acute attack of gout has settled. For patients who are already on allopurinol, however, they can continue taking their medication without adjusting the dose. Simply treat the acute attack.

4. Check the fingers for tophi.
5. Patients who have tophi may not be able to feel it. A dual-energy computed tomography (DECT) scan may help differentiate between gout and pseudo gout.

ONE DOSE OF BALOXAVIR CUTS FLU TRANSMISSION

Findings from a large multicountry trial, published in *The New England Journal of Medicine,* demonstrated that treatment with a single oral dose of baloxavir marboxil significantly reduced influenza transmission from infected individuals to close contacts.[6]

Baloxavir has shown efficiency as treatment and post-exposure prophylaxis for influenza. Baloxavir was shown to rapidly reduce influenza virus titers and stop shedding of infectious virus faster than oseltamivir, suggesting it can reduce transmission.

Most individuals in the trial had influenza A — H3N2 or H1N1 pdm09 — infections, while 20% had influenza B infections. By day 5, laboratory-confirmed influenza transmission was significantly lower in households where index patients received baloxavir compared to placebo.

The availability of an antiviral drug for influenza A and B with dual treatment effects on illness and transmission is a welcome addition to the overall strategy for influenza control. Although vaccines will remain the primary control measure for influenza epidemics and pandemics, antiviral drugs play a complementary role, particularly in a pandemic scenario, as well as in persons who are not vaccinated seasonally.

Choosing Wisely

Originally published in the Fall 2015 issue of JLGH *in conjunction with the American Board of Internal Medicine's now-complete Choosing Wisely campaign, this edited reprint is offered to remind physicians of the importance of talking with patients about what tests, treatments, and procedures are needed — and which ones are not.*

RECOMMENDATIONS FROM THE SOCIETY OF HOSPITAL MEDICINE — ADULT HOSPITAL MEDICINE

❶ **Don't place (or leave in place) urinary catheters for incontinence or convenience or monitoring of output for non-critically ill patients.** To monitor diuresis, weigh the patient instead. Acceptable indications for a catheter are critical illness, urinary obstruction, hospice care, or perioperative use (for less than two days) for a urologic procedure. Published guidelines suggest that hospitals and long-term care facilities should develop, maintain, and promulgate policies and procedures for catheter insertion, including recommended indications, insertion and maintenance techniques, discontinuation strategies, and replacement indications.

❷ **Don't prescribe medications for prophylaxis of stress ulcer in medical inpatients unless they are at high risk for GI complications.** Evidence-based guidelines do not support their use for adult patients in non-ICU settings. Both histamine-2 receptor antagonists and proton-pump inhibitors are associated with adverse drug events and increased costs. Community-acquired nosocomial pneumonia and *Clostridium difficile* susceptibility can be enhanced by these drugs.

❸ **Avoid transfusions of red blood cells for arbitrary hemoglobin or hematocrit thresholds in the absence of symptoms of active coronary disease, heart failure, or stroke.** The American Association of Blood Banks recommends adhering to a restrictive transfusion strategy (7-8 g/dL) in hospitalized, stable patients and suggests that transfusion decisions be influenced by symptoms as well as by hemoglobin concentration.

❹ **Don't order continuous telemetry monitoring outside of the ICU without using a protocol that governs their continued use.** In patients with low-risk cardiac chest pain and a normal electrocardiogram, telemetric monitoring has limited utility or measurable benefit. Published guidelines for its use provide clear indications that are contingent upon the frequency, severity, and duration of symptoms, as well as the conditions under which they occur. Inappropriate use is likely to increase the cost of care, while potentially producing falsely positive findings that can lead to errors in patient management.[7]

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